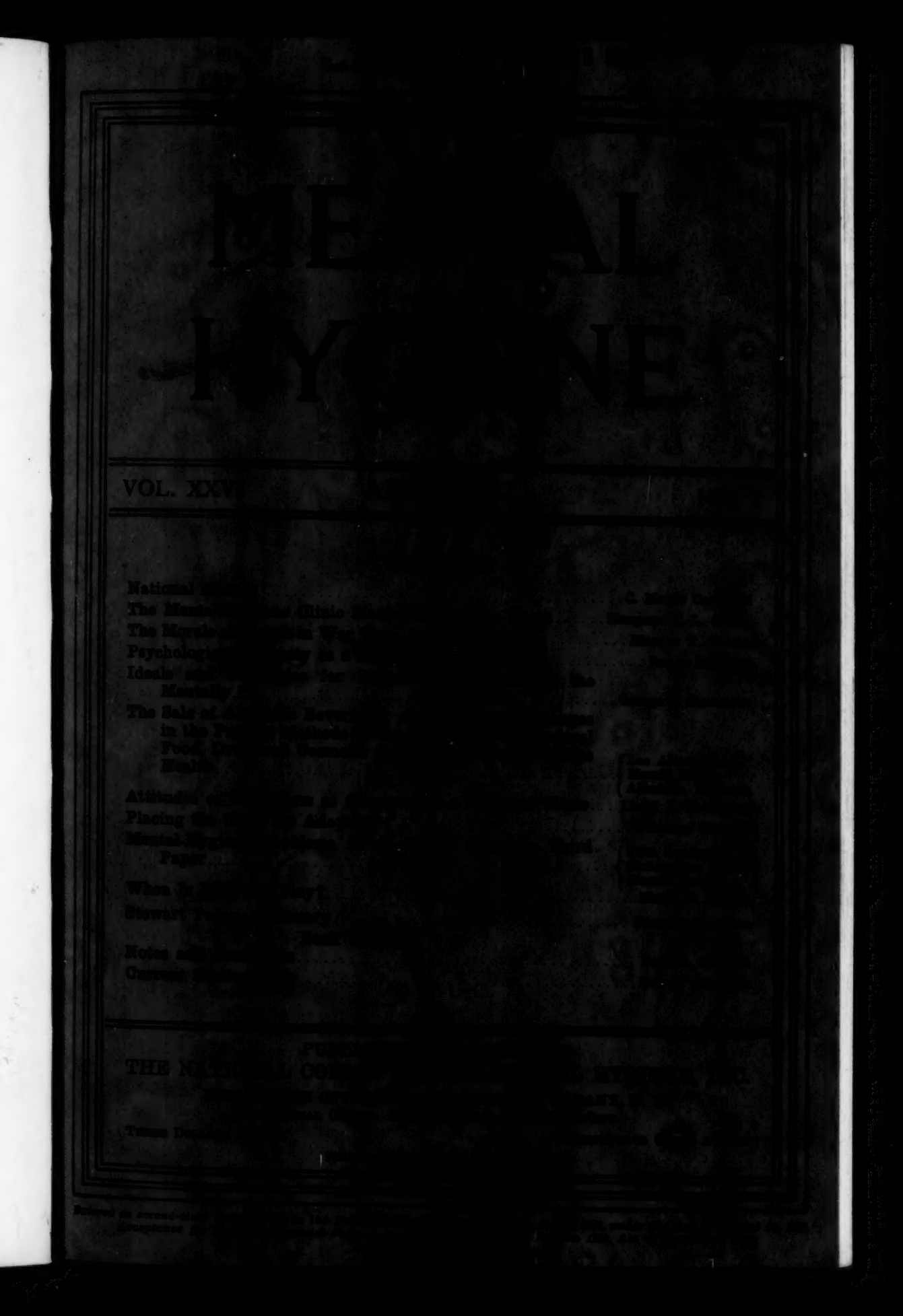

MENTAL HYGIENE

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NATIONAL MORALE *

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AN unconventional fellow of All Souls College, Oxford, had a trophy from his recent Arabian adventures—a bell snatched from a Turkish railway station. One day he startled a poet friend by violently ringing the bell out of the window of his college rooms.

"Good God!" said the startled poet. "You'll wake up the whole college!"

"It needs waking up," said the unconventional fellow.

At the present moment it is more than a single college that needs waking up; many are anxiously praying that the united citizenry of this country may wake up in time. To some citizens the declaration of an unlimited national emergency has been as startling as the ringing of that station bell. They had dozed off with complacent confidence in the automatic march of human progress and in the establishment of a reign of reason. The declaration of a national emergency woke them rudely from their dogmatic slumbers.

They awoke to find that the apparent stability of life, with its accepted codes and material security, is a thing of the past. They awoke to find the situation as formulated by General Smuts in 1918: "There is no doubt that Mankind is once more on the move. The very foundations have been shaken and loosened and things are again fluid. The tents have been struck, and the great caravan of humanity is once more on the march."

This violent awakening of humanity from its comfortable, but temporary, halt means that it must again struggle on

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till it finds another resting place. The awakening, the challenge, the summons to move on, forces this nation to an unaccustomed survey as to where it stands, whither it is going, what resources it has for attaining its goal. The nation and each of us individually are forced to consider what are the values on which we lay most weight, what we can do to retain them, what sacrifices we are willing to make for them, and what resources are available for maintaining them—these values with which we as individuals and as a nation identify ourselves.

The ordinary easy-going individual does not as a rule keep a very precise account of his resources. Once a year perforce he takes account of where he stands in a financial way, urged to it in January by a somewhat stereotyped letter of inquiry from the Treasury at Washington. Few individuals have a systematic review made of their bodily condition at regular intervals; still fewer keep track of their spiritual fitness. Emergencies, however, may arise that force the individual to survey his financial status with the greatest care. In some emergencies he may even need to review his ability to sustain physical effort and hardships. In other situations, with decisions to be made, he may have to take stock of where he stands with regard to the ultimate verities. So the nation is taking stock of its resources, and among these resources the human factor has to be evaluated—the quantity and quality of its man power; the physical, mental, and moral qualities of its citizens; and the nature of the bonds that bind them together.

With regard to the physique of the nation, the application of the Selective Service Act has already demonstrated facts of which the community had previously been unaware, or to which it had been strikingly indifferent. The nation has found with regard to its young manhood that three out of every five selectees who appeared before the local-board physicians failed to meet the physical requirements for military service. Many of the defects observed could have been prevented or remedied, if the individuals or their families had had an intelligent interest in bodily health, or if the community inspection and resources for treatment had been adequate.

The physical health of the individual or the group has an

important bearing on morale. A hungry man is an angry man, sometimes an unsympathetic and unjust man; an undernourished man is a discouraged man. In the face of malnutrition, infection, pain, sleeplessness, a man is not quite himself; he has not the initiative, the courage, the endurance, the confidence of his normal self. The historian and the sociologist may consider the relation of malaria to the decadence of Greece and of Rome, the rôle played by the hookworm in the economic history of some Southern states, the influence of climate and of diet on the mental attitude of the peasant population of the Orient.

Quite apart from the fact that morale depends to a certain extent on physical health, the Selective Service observations made another contribution to a study of the morale of the community in peace time. It gave a certain measure of the degree of interest of the community in the physical health of the individual. Apparently the community had taken no active steps to find out these defects, or was unconscious of their existence, or had taken no adequate measures of a preventive or remedial nature. Good physical health is important in peace time as in war time. The number of selectees rejected for military service may perchance awaken the community to its sins of omission—may stir a resolve to review systematically the community health and to make what effort and sacrifice are necessary to deal with this basic community problem. Measures thus taken under the stimulus of the emergency, and partly in relation to emergency needs, would continue to bear fruit when the emergency is past.

In order to avoid self-deception, let us humbly remember that similar observations on the physique of the nation were made in 1917 and 1918. These observations led to various suggestions and plans, but after the armistice was declared, the community settled back to its slumbers until the bell should ring again.

The physique of an individual is not a fixed condition, so much inherited capital. It is in part the product of the individual's own past experiences and activities, training and habits. Into the latter there enter personal effort, self-control, purposes of various levels. The individual may have purely egoistic goals. On the other hand, he may be pre-

paring himself for some high endeavor, either a quite specific goal, like exploration or national service, or some vague crusade, the form of which is not yet clear.

Milton once wrote to a public-spirited friend a letter or tractate giving his views on the reforming of education, "for the want whereof this Nation perishes." "A compleat and generous Education," according to his definition, "is that which fits a man to perform justly, skilfully, and magnanimously all the offices both private and publick of Peace and War." In the curriculum that he outlines he includes physical exercises:

> "The Exercise which I commend first, is the exact use of their Weapon, to guard and to strike safely with edge, or point, this will keep them healthy, nimble, strong, and well in breath, is also the likeliest means to make them grow large and tall, and to inspire them with a gallant and fearless courage, which being temper'd with seasonable Lectures and Precepts to them of true Fortitude and Patience, will turn into a native and heroick valour, and make them hate the cowardise of doing wrong."

Thus, for Milton, physical exercises, accompanied by precepts, favored the well-being of the body, helped to develop courage, prepared the student to play the man should the state ever have need of him, and made him hate wrongdoing.

I have already several times used the term morale, without attempting to define it. I assume your permission to use the term in a fairly broad way. In general the term morale refers to the fiber of a man's personality, or to the habitual conduct or behavior of a group. It is most familiarly used in relation to a body of troops, especially in relation to their courage, endurance, confidence, discipline, stability, cheerfulness. The troops of Wellington in his Peninsular campaigns were a rough and drunken lot; under his discipline their conduct improved, and by the end of his Peninsular campaign, the British army acted as one, the divisional commanders working loyally for the common welfare. One division traversed the greater part of France, "not only without a single crime, but without a single complaint of any inhabitant against a single British soldier." One could, therefore, refer to the high morale of these troops, the result of a discipline imposed upon them. One must also mention the not unimportant fact that they were well fed.

The morale of the choice cutthroats whom Lawrence of Arabia collected for his bodyguard might also be considered as very high. Discipline was severe, but the dominant factor in their service was complete devotion to their personal leader.

No troops have excelled in morale Cromwell's Ironsides, those God-fearing troops, trained by him in an iron discipline, in whom he inculcated his views that "duty—obedience to God's orders—was the first step to discipline—obedience to man's orders."

It is evident from these examples that rigid external discipline, intense personal devotion to a leader, and wholehearted acceptance of religious beliefs may give unexpected power to a military group, whether measured by courage in attack or by endurance of hardship.

While an army, with its common purpose, recognized even by the private soldier, and its habits of comradeship, has a sort of corporate unity and can be said to have a definite morale, what analogous unity can we expect in a whole nation, subject to little discipline, with diversified interests, active rivalries, and opposed economic, social, political, and religious beliefs? One cannot formulate the purposes of a nation in peace time as precisely as the purposes of an army. One cannot indict a nation; and it may be an elusive task to sum up its qualities in terms of morale. Such a task, to be adequately carried out, would require the help of the erudite historian, the economist, the sociologist, the political scientist, the industrialist, and perhaps the theologian and the philosopher.

The psychiatrist, dealing as he does with the personal difficulties of individuals, must not claim any special competence in the broad social or political field. His contribution to that field is his knowledge of the human personality, derived from his daily activities under the special circumstances of his professional work. In the neutral atmosphere of the consulting room, the individual patient can put aside the reticences, the conventions, the evasions that protect him from the scrutiny of others, and even from that of his own official personality. With the help of the physician, the patient may review the real significance of his acts and

thoughts and emotions; he may try to evaluate honestly his present, his past, and the future he dreams about. Such a review may be of practical benefit to the patient; it enables him to ventilate repressed factors, to face important personal problems, to digest disturbing memories, to come to an understanding with himself.

Quite apart from the practical benefit to the individual patient, the procedure has revealed much about human nature that otherwise would have remained obscure, and we now have a much better insight into the complicated processes that go on beneath the threshold of consciousness. The real man is the man as he usually appears plus this subconscious man, with whom the former may not be on speaking terms. When the physician is called on to deal with any problem of individual difficulties or with problems of human relationships, he thinks in terms of the real man, not of the social fiction.

So when he is given such a comprehensive topic as national morale, he would like to introduce into its discussion something that otherwise might be omitted—namely, the human nature of the individuals that make up the nation, with their crude instincts and their emotions, their childhood experiences, their self-seeking tendencies, as well as their official ideals and beliefs and motives.

When one talks of national morale, one thinks in a general way of the following factors: the degree to which the general body of citizens are accustomed to pull together in matters of national importance; the existence of a common purpose or code of values; the nature of these values; the degree of emphasis on ethical values; the intensity of personal convictions; the willingness to subordinate individual or group interests to national interests; the willingness and ability to endure restrictions or hardships for a cause espoused.

The morale shown by a nation in face of an emergency will be determined by its habitual reactions to the varying situations that have made up its history. The ability of a nation, as of an individual, to meet a physical or a moral emergency will depend upon previous habits of physical and moral exercise. If not in training, the individual exposed to the physical test may soon be out of breath. If his moral

faculty has become rather flabby, a spiritual challenge may find him inadequate; he may easily become irresolute and discouraged and compromise with his conscience.

The reaction of the individual citizen to national problems will depend in part upon his habitual reaction to the everyday demands made upon him by more parochial matters in his home, his occupation, his social contacts. National morale depends on the character and habits of its individual citizens and on the degree to which they have worked out the problem of social living in their various associations and communities. There can be no exalted national morale if the majority of the individual citizens are exclusively preoccupied with material gains, egoistic satisfactions, rivalries, and prejudices of varied nature. In his daily life each individual makes his own contribution to national morale. The call of a national emergency summons him to scrutinize that contribution.

Each individual is a social unit, a member of various groups, and from his membership in these various groups the individual gets practice in social living, develops habits and loyalties, acquires standards. He will be all the better prepared to make his appropriate contribution to the national service, whether in peace or in war, if his experience in these groups has been wholesome. Poor family influences, unsatisfactory school experiences may determine the attitude of the individual in later life toward all authority and toward many problems of social life. The morale of the nation has its roots in part in the early family life and the school training of each of its citizens. National morale represents the integration of the social forces and the moral values that form the daily life of its varied communities and of the individual citizen as he goes about his lawful occasions.

. In estimating the morale of a community, one would consider in detail its concrete activities—educational, recreational, hygienic, philanthropic, cultural—and the extent to which these activities are supported by the serious interest and coöperative effort of a large proportion of the community whose purposes they express. One would, specifically, be interested in the opportunities available for the development of the young; in the sensitiveness shown with

regard to the care of the sick, the handicapped, and the dependent; in the respect for the human personality and the needs of the individual shown in commercial and industrial establishments; in the spontaneity of coöperation in important civic projects; and in the degree of kindliness and lack of prejudice that characterize the social life. What especially stamps the morale or worth of the community is the degree to which it is integrated and to which it is permeated by a certain uniform outlook and code of values that bind people together in their daily life.

Communities vary in their morale, and the morale of the same community may wax and wane. At one period there may be a higher level of community resolve, a more adventurous and progressive spirit. Then again enthusiasm may wane and people protest to the advocate of further progress:

> "Let us alone. What pleasure can we have
> To war with evil? Is there any peace
> In ever climbing up the climbing wave?"

In discussing the morale of a community, I have made no reference to the standard of living, except in so far as specifically human values are concerned. Malnutrition and poor health may lower morale, but morale does not necessarily rise with the material resources of the community. A community that lays undue emphasis on material comfort arouses our suspicion. The most important needs of human nature may be somewhat neglected by those who emphasize in their social aims a chicken in every pot, a car in every garage, a bathroom for every bedroom, a radio in every living room, and an illustrated magazine for every armchair.

There are those who preach a doctrine of comfort, security, and peace, and to these topics man's fundamental inertia and pleasure-seeking endowment tend to respond. They may fail, however, to make an appeal to the more valuable qualities in human nature. Comfort, to a certain extent, may promote efficiency, but if it is a goal in itself, it may cumber the soul. Security tempts us with its elusive suggestion of finality and relaxation, but perhaps there can be no security worth having save at the price of fixed resolution and constant effort. Peace is the dream of troubled mankind, so often involved in needless and ignoble strife where the issues

are obscure and touch no responsive chord in the individual soul. Peace as the opposite of unworthy strife is devoutly to be desired. Under the conditions of peace, man can add richness and value to life, not to mention material comforts and technical facilities. As the expression of human good will, peace may forward man's highest aims. If, however, peace be the expression of human inertia, timidity, egotism, desire for comfort, indifference to the needs of one's neighbors, then it cannot claim to be of any intrinsic value.

Words are sharp-edged tools; they may be used for many purposes—to stir up emotions, to confuse issues, to cloud understanding:

> "For words, like nature,
> Half reveal and half conceal the soul within."

The Prince of Peace said: "Think not that I am come to send peace on earth: I came not to send peace but a sword." Peace itself, therefore, must be looked upon as of neutral value and not significant. The question is whether, under conditions of peace or of war, the individual and the nation are following the dictates of conscience.

In social and political life there is often the alternative of accepting an unworthy status, on the one hand, or, on the other hand, of putting forth effort and beginning a resolute fight in behalf of some fundamental moral principle which touches us. In undertaking a campaign against evil in one's own society in peace time, life is not at stake. In undertaking a campaign against evil that involves actual war, with consequent loss of life—not to mention secondary economic consequences—some are so struck by the tragedy of the curtailment of young lives that all other considerations fade into insignificance. They seem to lay exclusive emphasis on the duration of life—make little mention of its spiritual quality. Neglecting its spiritual quality, they would condemn rather than praise the generous ardor of those who wish to accept the gauge of battle thrown down by what they consider to be the forces of unrighteousness. The Roman poet considered it "sweet and seemly to die for one's country," but some may see merely imprudence and nothing seemly in risking one's life for those principles which one likes to think of as the essential glory of one's country. It is true that,

while each man must answer to his own conscience for his own individual action, complex social considerations enter in, since final decisions will involve not only his own life, but the lives of his fellows.

The most critical decisions with regard to the foreign policy of a nation are in part determined by data and considerations with regard to which the individual citizen has little information or competence to form an opinion. National morale is sound when the citizens insist that national as well as personal decisions be based upon moral principles. In a democratic form of social organization, which lays great stress upon both the freedom of the individual and the social integration of the community, free discussion plays an important rôle. Opportunities for free discussion, each man having the opportunity to state his point of view, lead to a final decision which may be generally and loyally accepted.

Not infrequently some individuals put forth their views with emotion and with great persistence and find it difficult to accept the verdict of the majority. It is here that a general familiarity with the principles of mental hygiene may be of considerable value. A little self-scrutiny and review of his personal experiences may sometimes help the individual to see that the emotion and emphasis given to his views were derived from sources previously overlooked. A reasonable amount of self-knowledge enables individuals to face the problems of social living more objectively, to understand their own motivations more clearly, and to avoid projecting on to others unrecognized factors in their own personalities.

This knowledge of one's own personal equation contributes to the morale of the community by eliminating many unnecessary conflicts and by promoting mutual understanding. It is of equal value in the home and in the schoolroom. Familiarity with this principle safeguards the discussion of national and international, as well as of parochial, affairs. It is well for the statesman to realize that his official attitude toward the doctrines and behavior of nations and of persons may really be determined by his own childhood circumstances, by early jealousies and failures, by disturbing instinctive trends. In Geneva no psychiatric committee

was established to give the representatives of the nations an opportunity to review their individual psychology and to scrutinize the medium through which they looked at world affairs.

For all those who seek high office and who desire to guide the destinies of the nation, or who thrust unsolicited advice upon it, a reasonable measure of self-knowledge should be an essential preliminary. Where self-knowledge is widespread, the possibility of meeting on common ground and working whole-heartedly for the common purpose is greatly advanced. The fate of the world might have been somewhat different if the protagonists in the discussion of the League of Nations had spent more time in scrutinizing the personal factors that played a part in determining their own attitudes.

In discussing the complex and somewhat elusive topic of national morale, it may not be out of place to take two concrete examples of how the attitude of the community toward an important human problem may steadily improve, so that the community is knit together more closely through bonds of kindly fellowship. One is the growing insight into the needs of the individual child and the growing effort to meet these needs. The other is the broadening grasp of the importance of the human factor in our economic and industrial life and the beginnings of systematic efforts to afford the worker the human satisfactions necessary for a wholesome life.

As to the child, the earnest endeavor of a pioneer group in the United States to study the facts of juvenile delinquency led to the establishment of various demonstration child-guidance clinics. The value of these was soon recognized, so that they were assiduously copied throughout the United States. Their influence on the conditions under which children are now being raised throughout the country is noteworthy.

In this connection perhaps a brief digression is permissible. These clinics in America inspired the establishment of similar clinics in Great Britain, and in 1939, when three-quarters of a million school children were abruptly evacuated from London and the large provincial cities, workers trained in the principles of child guidance were found to be of very great value in dealing with the special nervous

difficulties of many of these children. The problems of the evacuated children were found to be the same as those of many children in the reception areas, and the parents in the reception areas were glad to utilize the hitherto unfamiliar resources of the child-guidance clinic. Thus the procedures initiated in the United States in time of peace have been carried by the wave of evacuation into the more sparsely settled rural districts of England, which might have awaited them in peace time for many years. The awakening of the country as a whole to the conditions of the city life of children will probably have far-reaching effects on social reorganization in Great Britain. One is glad to note any item on the credit side of the war account.

The second trend bearing on community morale that I referred to is the growing sensitiveness to and interest in the health, the comfort, the mental welfare of the average worker, whether in factory, office, or store; the unskilled worker receives less attention. These workers keep the machinery of our economic life working smoothly, but those whose comfort depends on them may be singularly insensitive to their needs. The salesgirl was not supposed to sit down, even when not busy; the iron-worker might get soaked through at his work while management remained completely indifferent, not thinking it worth while to take the simple steps necessary for his health and comfort. "A curious lack of provision for the comfort of the men on the part of some of the employers," is the note made by one investigator in a mill (England, 1920).

The traditional view of industry has been that it turns out goods; it is becoming increasingly evident that another product of industry is equally important—viz., human satisfactions. This no doubt has long been recognized intuitively and acted on by a number of owners and managers; they have taken as much pride in the satisfaction of their workers and the morale of their working force as in the amount of goods manufactured or the dividends paid to stockholders. Since the last war, research in industry—at first preoccupied with such factors as the physical condition of the plant, job analysis, methods of payment, influence of rest pauses, and so on—has come to pay more attention to the detailed per-

sonal and social factors involved in the human associations of the factory.

The personal equilibrium of the individual worker, as determined by emotional conflicts and home situations, has its influence on his output. In addition, the social atmosphere of the job, the bonds that automatically develop when individuals work in a group, the interplay of personal relations between fellow workers, the attitude to supervisors and management, influence output. At the same time these factors determine the quality of the worker's personal experience on the job, the value in terms of human satisfaction of that large proportion of the worker's life spent at bench or machine. Even hours and wages must be thought of in other terms than merely bookkeeping or budgetary items; of still greater importance to the worker may be their significance as symbols of personal status or of the spirit of fair play.

So the morale of the factory begins to receive the attention it deserves. The way in which the individual factory or industry may dovetail into the life of the community and influence its morale, as a powerful integrating factor, is a field for further study, analysis, and experimentation. If the industrialist is seriously interested, not only in his special products, but in the human satisfactions of his employees, and in the morale of the community of which his factory is an organic component, he may also be interested in the relationship of his industry and output to the needs of the nation as a whole. He will think of the nation, not as a bloodless economic system, but as a social system, the welfare of which depends upon due allowances being made for the satisfaction of the individual and upon a healthy morale determined by wholesome relations between individuals and groups.

Where groups of workers are involved, whether in a temporary or a steady job, skilled or unskilled, in industry or agriculture, human nature cannot be ignored with impunity; otherwise one may expect labor unrest, riots, class conflicts, economic demoralization. Local or widespread discontent, episodic manifestations such as the I. W. W. or its modern equivalents, are symptoms of a disorder of our social and economic system. One cannot understand these

symptoms without taking into account the instinctive and emotional factors in the life of the individuals involved, their frustrations, repressions, compensations, and projections.

In discussing the morale of a community, little mention has been made of the beliefs of the members of the community. This topic might seem to lie outside of the field of the physician. His business, however, is to help the suffering individual, to study his patient's symptoms, to analyze the disorder, to seek out the resources for treatment. In dealing with his life difficulties, the human individual may find a great support in certain beliefs. Not infrequently patients have abnormal beliefs.

To many people life would be intolerable were it not for certain beliefs. When for some reason the familiar beliefs no longer suffice, they have to improvise beliefs adequate to their needs. The average individual accepts the beliefs of his culture as he accepts its other aspects—its diet, customs, folklore, social structure. He accepts his place in the social system, even though it involves drudgery for a meager wage. In the light of his traditional beliefs, he may carry on contentedly, feeling that his restrictions are temporary, that inequalities are unimportant, that there are eternal verities in the background. He may feel that he plays his part, however humble, in a process of infinite significance,

> "With one far-off divine event
> To which the whole creation moves."

There are some who regard such beliefs as an impediment to progress, as a soporific, retarding efforts to improve what is open to improvement, to correct whatever injustices and inequalities are open to modification. They claim that one basis for the persistence of such beliefs is the interest of the privileged in maintaining the *status quo*. Impressed with the triumphs of science, these critics reject religious beliefs as not based on observation, experiment, or the methods of the laboratory. But the physician who deals with human nature in trouble is interested in the support that such beliefs give to the individual in trials for which there may be no objective remedy, such as bereavement, mutilation, or crippling illness.

There is very unequal distribution of wealth and material resources in the community and something can be done to

modify this. But there are other inequalities; men are born unequal in their physical and mental endowments, quite apart from acquired inequalities or inequality of opportunities, as determined by the time and place of birth.

Religious belief may compensate for inequalities of all sorts; it gives significance to life, it binds men to one another, it does justice to the aspirations of the individual, it places actual inequalities and hardships as transitory and negligible phenomena on a cosmic background. Such beliefs are not to be exploited by the privileged in order to safeguard their privileges, but neither are they to be tampered with because of their possible misuse or their inability to meet certain intellectual criteria. No other factor binds men more closely together in a stable union; no other factor enables the individual or the group to show such unflinching resolution, such courage in the face of danger, such endurance in the face of hardship.

In the national morale of Great Britain to-day, the solid support of the Labor Party is of fundamental importance, and the attitude of that party to national issues is largely colored by its religious background. Where in a nation there is great diversity of belief, as between Hindu and Mohammedan, the religious factor may be more a source of friction than a social bond. But within the Christian faith the central doctrines recommend so strongly the kindly bonds of social life that minor differences of doctrine can only partly reduce its unifying influence.

What about national morale in an emergency? In ordinary times the nation comes to its decisions in an orderly way, with traditional procedure; after due discussion, it comes to a conclusion. The decision represents the opinion of the majority, or is perhaps a compromise; or the situation may be such that a decision is postponed. As a rule the community as a whole accepts the decision and in the spirit of group loyalty each one adapts his life to the new decision as one of the definite conditions of social life. The memory of the Prohibition Act is rather painful and furnishes food for thought. It may show that human procedures and institutions are still faulty and open to improvement and that we do not quite have the social sense of the Melanesians.

Dr. Rivers, a distinguished psychologist, anthropologist, and psychiatrist, made some interesting observations on social life in Melanesia:

> "The Melanesian is distinctly more gregarious than the average European. His whole social system is on a communistic basis, and communistic principles work throughout the whole of his society with a harmony which is only present in certain aspects of the activity of our own society, and even there the harmony is less complete than in Melanesia. As an example of such harmony I give the following experience. When in the Solomon Islands in 1908 with Mr. A. M. Hocart, we spent some time in a schooner visiting different parts of the island of Vella Lavella. Whenever we were going ashore, five of the crew would row us in the whaleboat, four rowing and the fifth taking the steer-oar. As soon as we announced our intention to go ashore, five of the crew would at once separate from the rest and man the boat; one would go to the steer-oar and the others to the four thwarts. Never once was there any sign of disagreement or doubt which of the ship's company should man the boat, nor was there ever any hesitation who should take the steer-oar, though, at any rate according to our ideas, the coxswain had a far easier and more interesting task than the rest. It is possible that there was some understanding by which the members of the crew arranged who should undertake the different kinds of work, but we could discover no evidence whatever of any such arrangement. The harmony seems to have been due to such delicacy of social adjustment that the intention of five of the members of the crew to man the boat and of one to take the steer-oar was at once intuited by the rest. Such an explanation of the harmony is in agreement with many other aspects of the social behavior of Melanesian or other lowly peoples. When studying the warfare of the people of the Western Solomons I was unable to discover any evidence of definite leadership. When a boat reached the scene of a head-hunting foray, there was no regulation who should lead the way. It seemed as if the first man who got out of the boat or chose to lead the way was followed without question. Again, in the councils of such people there is no voting or other means of taking the opinion of the body. The people seem to recognise instinctively, using this much misused word in the strict sense, that some definite line of action shall be taken."

When we think of our own political discussions, how admirable the social sense of the Melanesians seems to be! Even in a head-hunting expedition, the group intuitively organizes itself behind the front man, even though the position of the front man appears to be more or less incidental. Evidently it is not so much the prestige or the unusual skill or experience of the leader that is important as the unquestioning loyalty and coöperation of his fellows. It may be that if high executives in this country were chosen from a limited group

by the brief and economical method of tossing a coin, the result would be quite satisfactory provided his fellows immediately fell in behind him and gave him loyal support.

The question of social collaboration, of loyal support, of subordination of the views of the individual to the consensus of the group, so important for the welfare of all communities and of the nation in normal times, is of special importance when an emergency arises. A physician is familiar with emergencies, and may be entitled to suggest certain analogies. In the course of a chronic illness, opinions may differ as to the nature of the disease, the form of treatment, the time to apply a specific treatment, and a consultation may be held. The whole situation is ventilated, the difference of opinions is recognized. Various solutions of the difficulty are possible—one may postpone all special treatment till the situation is clearer; one may compromise; one may agree to give first one treatment a trial, then, if this be unsuccessful, to try another. Time is available.

But suppose there is an emergency; suppose death is imminent unless something is done and done quickly. Shall we ignore the time element and carry on the discussion while the patient perishes? If that surgeon who, by virtue of his official position, is obligated to carry out any crucial procedure is anxiously preparing the appropriate measures, shall we continue to express doubts about his infallibility, make insinuations about his motives, review his past conduct of the case, question the diagnosis, and deny the emergency? Or shall we recognize what is meant by an emergency, realize that the time for discussion is over, and do all that is possible to support the operator, so that his hand is steady, his resolve strengthened, his confidence reënforced by the knowledge that he has the complete and loyal support of his fellows?

It is not for a psychiatrist to decide when a national emergency exists, but he might make the following remarks: The individual citizens collectively have put their affairs in the hands of an elected group. Before the individual citizen thinks fit to urge loudly his personal views on the nature or management of a national emergency, he would do well to

search his own heart in all humility, to make sure of the medium through which he sees the world in which he lives, and to meditate perhaps on the ways of the Melanesian.

It is to be hoped that the national morale is adequate to the demands of the present emergency. We must remember that national morale is not the function of a special bureau in Washington; it is the function of every citizen. A challenge has been made to each one of us. We have been awakened to external danger and to the immanent spiritual issues of our daily life. The national morale will be measured not only by the reaction to the emergency, but also by the degree to which the citizens remain awake after the emergency is over.

As a symbol of the awakening, I personally like to think of Lawrence of Arabia ringing his Turkish bell out of a college window.

THE MENTAL-HYGIENE CLINIC MEETS THE DEFENSE BOOM

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New Haven, Connecticut

I.

EARLY morning sunshine lights up the waiting room of the clinic. The building is old, the air heavy with dust from the factories, and the flood of light impartially points up the rain-spotted windows, the shabby overstuffed furniture, and the waiting people. There is the glum and rebellious Henry Jenkins, sitting with his mother, eyes cast down. He "borrowed" another car yesterday after weeks of good behavior. There is Doris Leskowicz, smiling this week. Each time she has been in the waiting room before, there have been tears. And there are the Pedros, she fat, he thin, both simmering with ill-repressed Latin emotion. Then there are several new patients sent to the clinic by schools, courts, social agencies, or doctors, waiting to discuss their problems with the staff. Each face is a study in emotional expression. Each patient presents new problems, new assortments of social, racial, and personal difficulties.

This particular community clinic is in Brookville, an industrial city in one of New England's many valleys.[1] The river running down through a hilly terrain has furnished water power for the manufacturing concerns strung like beads along its length since Colonial days. To work in these industries during prosperous times, populations of foreigners of many nationalities have sprung up. Here will be a colony of Finns, there a town within a town of Poles and Lithuanians. Scattered everywhere are groups of Italians mingled with second- and third-generation Irish. In groups on the hillsides are the descendants of the original Yankee settlers,

[1] EDITOR'S NOTE: Though the name is fictitious, Brookville is a real city, and the conditions described here are conditions that actually exist. The real name of the place is withheld as immaterial, since the situation with which Brookville is faced is not peculiar to this one town, but is that of every American community upon which the defense boom has suddenly descended.

who have left their farms to work in the factories during boom years, and who have gone on relief with the rest of the population during depressions and panics. Many have intermarried with the foreigners, and many youngsters who consider themselves Yankees bear formidable Slavic names.

These modern industries and their Colonial ancestors have played important parts in the defense of America since the Indian wars before the Revolution, but the present effort for defense is the most pervasive and intensive of any. Every individual living in the valley is swept along by the tide of national emergency, and every problem coming to this clinic has been patterned in part by the defense boom, just as all the cases of 1932 and 1933 bore the stamp of poverty and insecurity. Even in ordinary times a psychiatric clinic in an industrial community encounters specific problems that are not met with in an agricultural region—like most of Vermont, for instance, with its predominantly Anglo-Saxon population. Situations presented to the doctor every day are colored by the racial traits of the patients as well as by the circumstances in which they are living out their lives. This year the most overwhelming circumstance is that of national emergency, with its unremitting vibration, affecting the lives of every human being in the valley.

As the cases stream through the clinic day by day, it becomes apparent that this defense program has created three major types of social-emotional problems. First, there has been a shift of population from the rural districts to the factory towns. Truck gardens, poultry farms, dairy farms have been deserted because there is no help available to run them. More money is paid to workers in industry. Large numbers of these newcomers have found no place to live. Every industrial town has a housing shortage, and every available shack and attic have been pressed into service. A boy seen in the clinic recently, for instance, was one of a family of six, all living in one rented room of another family's apartment.

Second, many mothers of families are working in industries, and their children either have no direct supervision or have inadequate supervision from an older brother, sister, or neighbor. Or in some cases elderly relatives have come to

keep house and mind the children, bringing in their wake all manner of emotional complications. Thus the children are left without a maternal eye over them, and often in a state of protest against the mother surrogate. Juvenile delinquency increases, especially the minor types of delinquency arising chiefly from mischievousness, lack of directed activity, and boredom.

The third bristling mass of problems arises directly from the drive to accomplish this rearmament as fast as possible. Enormous effort is being made by all the factories to increase the man hours in every week. Men who have been used to working forty hours or less a week are now working sixty or seventy. Men who have always had simple daytime hours are now on the night shift and slow to adjust to sleeping during the day. Factories running at full speed show an inevitable increase in the number and seriousness of accidents; and as if this were not enough tension for each individual worker to bear, there is the added strain of being under constant watchful surveillance—the fear of sabotage and espionage. Emotions are strained and confused. Tempers are short and jumpy.

II.

Henry Jenkins, a large, gloomy fourteen-year-older, is sitting with his mother in the hall. The doctor sees her first because the factory has let her have time off to come to the clinic with Henry, and she is anxious to get back to work. She is a neat, attractive woman, middle-aged, who came with her parents to America from Hungary when she was a little girl. She speaks good English and is a most conscientious and hard-working woman. During the last war she made a good record working in the factory on a foot press. After the war she was laid off, and later she married a Connecticut Yankee by whom she had six children. Henry is the third. As soon as this defense boom got under way, the employment supervisor of the factory wrote, asking her to come in to work, offering her good wages and her choice of day or night working hours. Bills had been run up to feed and clothe her family during the depression and this seemed to her a God-given opportunity to get a little ahead with her family

finances. And besides that, it would be fun to get back to work. She had always liked the factory and the people she was associated with there. She had been on the shelf long enough.

She was perfectly well aware that the children might suffer, with neither parent at home, and so she settled on working during the 3-to-11 P.M. shift. Thus she could be home in the morning and get lunch when the children came home from school. In the afternoon she would have a high-school girl come in to look after the younger ones, and her husband would be home in time to get supper and put them to bed.

Henry is in the second year of high school himself, and it seemed highly undignified to him to be under the thumb of a girl who was just a year ahead of him in school. "That dope!" he called her. Besides this, his schoolmates twitted him about being a sissy on the rare occasions when he stayed home to look out for the younger children, and the combination of indignities was more than he could bear. So he began to make up stories for his mother about the things he had to do at school that prevented his being at home in the afternoons, and gradually he stayed away from home more and more. Finally his parents realized that the stories about school activities were largely fabricated and that he was actually spending a lot of time hanging around street corners with a group of boys who were even less supervised than he, and considerably less desirable. Then suddenly one day, about two months before this clinic morning, he and a couple of his cronies decided to "borrow" a car and go for a ride, to relieve the overwhelming boredom of existence. They selected for this a car that belonged to an acquaintance of theirs, and when they returned it undamaged, their friend was relieved enough not to press charges. The probation officer, therefore, reprimanded the boys and dropped the charge. The juvenile-court judge, however, knew something about Henry's family and the problems involved, and felt that perhaps something could be done by the clinic to throw light on the reasons for this type of behavior.

When Henry was first seen at the clinic, he was a rather sullen and pimply adolescent, large for his fourteen years, who made friends slowly with the clinic staff. He seemed

responsive enough, however, when he saw that nothing dreadful was going to happen. Psychological tests showed that he was slightly brighter than average, and that he had considerably better mechanical ability than most. When he warmed up a little and talked, it seemed certain that he had no clear idea of what he was doing from the standpoint of conventional morality. His motives were all vague, except for a dominating, overwhelming love of automobiles.

"Gee," he said with real bewilderment, "sometimes when I see a car parked on the street, I just can't hardly leave it alone. I don't see why we can't have a car, anyway. Lots of the other kids' fathers have. Gee, I'm nuts about cars and any kind of engines. I only borrowed it, anyway—I might have tuned it up a little for him if he'd given me a chance. Wouldn't cost him nothing, neither."

Aside from this his only discernible goal was to maintain "face" in the group of boys with whom he was hanging around. He was stuck emotionally in a back eddy of normal adolescent rebelliousness against his family—and especially the high-school girl who was *in loco parentis*—without any appropriate goals to give directional outlet to his pent-up tensions and energies.

The clinic staff felt that Henry had marked assets in the way of mechanical ability and energy, but that his general adolescent suspiciousness of adults, his defensiveness, and his evasiveness made it particularly difficult to modify his attitudes by psychotherapeutic interviews. Only minor measures, therefore, were taken at that time. No attempt was made to reorganize his life on a major scale.

Henry was sent to the Y. M. C. A. with the hope that he might find some companions there whom he would regard as socially acceptable. If he could establish more favorable contacts, perhaps the whole situation could be eased over for the present, and he would have a chance to develop his character and his goals more constructively. The clinic worker also talked to the principal of Henry's high school to see if possibly his program could be shifted slightly toward the mechanical training field, and it was found that this could be done the following school year, but not just at present.

The clinic doctor felt that it was not really desirable to

try to change the situation at home much. Henry's mother was insistent on the importance of keeping up her work in the factory. The matter of the high-school girl was talked over with both parents, and they agreed to try to find some older person to fill in, but when the clinic worker had last heard from them—a month before the current outbreak—they had been unable to find any one suitable. Some effort was made to give the parents insight into Henry's problems, but Henry had always been such a good boy that they did not take the immediate situation very seriously.

"Well, Henry, what happened this time?" from the doctor, gave him the opportunity to pour out a torrent of two-directional thought. First, he would absolutely not stay home afternoons with his mother away—not as long as "that dope" was taking care of "those brats." He wanted it clearly understood that no more outrageous suggestion could possibly have been made—a direct challenge, indeed, to his independence and manhood.

Secondly, he was still nuts about cars. "All I borrowed that car for was I wanted to tune it up. I didn't have no notion of smashing it up—and in fack, I'm sorry I did smash it up, and I'll say so to any decent fellow who asts me, but not that flat-foot—he's nuts hisself."

In substance it seemed clear that Henry's troubles arose directly out of his mother's return to work in the factory. His aims and goals were not definitely enough established to enable him to manage his adjustment to city life without her supervision. Could the situation be reversed? Could she return home and the family patterns revert to their status before her reëmployment? The clinic doctor thought not. In the first place, she was too happy in the factory, too pleased to be relieved from just child-raising for a while, and too delighted with her personal income. In the second place, it was hardly a progressive step to cloister the rebellious adolescent Henry again, even if it could be done now that he had made the break away from home.

Fortunately, it is going to be possible to find funds for Henry to go to boarding school—a special sort of boarding school that emphasizes character building and the develment of sound aims for the adolescent. The chief physical

asset of this school is a well-equipped shop where Henry will soon be immersed to his ears in automobile mechanics, happy and reassured about his entire future.

Henry's problem can be solved for the present, but not all the children of working mothers can be sent away. Many must be cared for at home, and not every problem can be settled arbitrarily. Some of the younger children will do very well at nursery school if space can be found for them, but most of the available nursery schools are crowded now. Some of them must be cared for at home under the eye of mother substitutes, and this means an enormously increased supervisory job for the agencies who are interested in keeping these homes going and the children developing normally.

III.

After Henry's problems were out of the way, Doris Leskowicz was found sitting in the waiting room with her mother. Doris is nine. Both her mother and her father were born in Poland, where her father was a peasant farmer. He came to America in young manhood and settled with his wife at once in a small New England village where he found a job as hired hand on a poultry farm. They had been happy there. Mr. Leskowicz had learned enough English to get on. Mrs. Leskowicz stayed quietly at home, keeping house and having four babies. Doris was the third. There were two older brothers and a baby sister. At first her husband interpreted America to Mrs. Leskowicz, and when the boys got old enough, they took over, so that their mother never felt the need to learn this strange, incomprehensible tongue, or to make any real adaptation to American ways.

Mr. Leskowicz had applied for citizenship papers almost as soon as he landed in America, and these had come through in due course. When the emergency came, one by one his acquaintances drained into the factory towns. Fabulous stories percolated back to the poultry farm. Mr. Leskowicz's imagination was fired with patriotic and slightly avaricious zeal. He persuaded his reluctant wife to close their cottage and move to Brookville, where a kind acquaintance had offered them a room in his apartment until the Leskowicz' could find a home of their own.

Moving was an enormous undertaking. Sensible Mrs. Leskowicz wept at leaving her comfortable home, her bulwark against American civilization. The widow who owned the poultry farm wept as the last available able-bodied man in the community marched off, leaving her alone with her chickens. And Doris wept at leaving her schoolmates and moving into a foreign town.

The move, however, was finally accomplished, and the six Leskowicz' settled stiffly into their one-room home. Mr. Leskowicz found the factory work confining, but tolerable. When he saw his pay envelope, he did not mind the long hours and the pressure of intense work. The boys transferred to the local high school without much difficulty. They were tough from outdoor work, and their athletic prowess made a place for them at once. Only the females were inconsolable. Mrs. Leskowicz, Doris, and the baby Jennie formed a babbling, weeping triple entente against the four walls and the foreign culture that hemmed them in.

Mr. Leskowicz did not have much time to look for another place to live. When Mrs. Leskowicz sallied forth to look, with Doris or one of the boys as interpreter, the most painful afternoons were spent and the most hopeless places found. Actually, the housing shortage was acute, and there were no decent "rents" available, but it was months before the Leskowicz' found this out. Meanwhile, three beds were jammed into their one room. Father and mother slept in one bed, the boys in another, and Doris and Jennie in the third. Doris had the short end of the deal, for Jennie was only three and she still wet the bed at night.

Doris might have survived even this indignity with a modest composure if the rest of her life had been going smoothly. The transfer in schools had been very hard on her. The parochial schools were so crowded they refused to take her. The public school, which was equally crowded, accepted her reluctantly. The teachers were already pressed beyond their capacities and the new pupils were only slowly being assimilated into the grades. Doris felt strange and provincial. Her clothes didn't seem right, her hair didn't seem right, and she had no best friend to whisper in corners with or to pass notes to.

The absolutely last straw came when the overtaxed room teacher was ill and a younger substitute allowed the boys to giggle when Doris mispronounced some words in her reading aloud. The boys called her a Polack. She flamed crimson and fled from the room, down the streets toward home. She flung herself into her mother's arms and swore a staunch Polish oath that she would never go to that school again, not even if she were thrown into jail. Her parents did what they could to be firm. They spanked her. They reasoned with her in English and in Polish. They cajoled her and bribed her. And finally realizing that there was no use in struggling against a will stronger than their own, they relaxed and let nature take its course.

In due time they were visited by the truant officer, who exhorted them all to reform, and threatened Doris with the most dire consequences of her recalcitrancy. But even he, after a week or so, knew when he was beaten, and when he reported back to the school, he mentioned a few of the facts he had observed on his visits to the home. The substitute teacher was well aware of the way in which she had failed to help Doris make the grade, and it occurred to her that perhaps the clinic could find a solution to the child's problems. So Doris and her mother came tearfully to the clinic, where they waited, stolid and unyielding.

The social worker who did the preliminary investigation was stirred to righteous indignation by the story, as item after item in the family situation came to light, and she made a personal investigation of the housing situation through the Chamber of Commerce and through real-estate offices. She found it just as bad as the Leskowicz' said it was. There really were no rooms available that were at all suitable for the family.

The doctor and the psychologist spent some hours on Doris and found her a reasonable, responsive child. She had perfectly good ability when she was reassured enough so that her panic was at least momentarily relaxed, but the mention of returning to school, the scene of her ignominous defeat, tightened her up so that she could hardly speak. She was a warm, responsive, sensitive youngster, gangling, lanky, pale, and tremulous.

It is a constant philosophico-psychiatric problem to guess how much adjustment can be expected from a given individual in a rigid, unmodifiable setting of external circumstances. Rather than accept the risk of another heartbreaking failure for Doris, it seemed wiser to alter the external circumstances if this could possibly be done. The clinic social worker, therefore, went to work to solve the housing problem. The only hope of obtaining a "rent" lay in the fact that a new government housing project was under way. But these "rents" would not be ready for another three months at least, and the situation really seemed too acute to try to tide it over for that length of time.

Meanwhile, the next time Mrs. Leskowicz talked to the worker, she showed her a letter from the poultry-farm widow. It appeared that their cottage was still vacant, and the widow was so badly in need of help with her chickens that she was thinking of selling out. The village they had lived in was only about twenty miles from Brookville. It seemed a simple piece of logic for Mrs. Leskowicz to move back to her cottage and herself take on her husband's old job of helping with the chickens. Their combined incomes would be enough for Mr. Leskowicz to trade in his present car for a better one. Doris could return to her old school. The boys could return to their high school until June, when the older one could join his father in the factory until the draft took him.

The excitement, the gratitude, the tears of joy that this brilliantly conceived program drew forth were really stirring. The move home was accomplished in twenty-four hours. That was two weeks ago. To-day the Leskowicz' have driven to Brookville with the father just to tell the clinic staff how happy they are, and how Doris loves her old school and her old playmates. And Mrs. Leskowicz is Americanizing so rapidly that she even attempts to speak English to-day. She is an independent, proud American career woman now!

IV.

Every doctor who has worked in community clinics will remember certain cases for their highly dramatic quality. The Pedro family had certainly proved to be an education

in this respect. They had been sent to the clinic by the exasperated city-court judge who had felt that the tides of emotion flooding and ebbing under the Pedro roof were far too complex for him to evaluate. He felt that the regular Saturday-night pandemonium in that home unleashed forces that no simple American could understand, and he hoped that the doctor would be able to clarify matters so that some direct action could be taken. The report from the court said simply that every Saturday night Pedro tried to kill his wife, that the children (of whom there were legion) took sides in the battle, and that even the baby exhibited bruises.

Mrs. Pedro had been voluble and excited when she had first been seen several weeks before. Pedro, she had asserted, was a drunkard, a brute, "a fif' column," a Fascist sympathizer, a Nazi, and in fact probably public-enemy number one. He was the cause of her being victimized by the F.B.I., or perhaps some more occult force. Aside from this, he drank up his pay check so that she could not pay the milk bill, and consequently the children were being deprived. This blast of invective burst forth in almost one breath. She was a large Sicilian whose English was more fluent than logical, but who was willing, now that she had stated her case in her own words, to discuss the situation reasonably.

She had married Pedro in Sicily fifteen years before and they had migrated almost at once to America, where Pedro had begun working in New England industry. He had become a citizen; they had raised many children and everything had been highly correct and satisfactory until the defense boom began. Soon after working hours began to lengthen, Pedro had been made a foreman, and ever since then he'd been "lik' a craz'." Especially on Saturday nights, when he would come home late from work, dreadful things would happen. He would drop dark hints about espionage, about the Black Hand, and about the way they dealt with unfaithful women in Sicily. She would counter with remarks along somewhat similar lines, relating to fifth columns, alcoholism, and the fact that if he had the F.B.I. after her, she would get the cops after him.

Every Saturday night this storm would work up like a tornado. The children would take sides, and they would

have at each other until the neighbors called the police, who usually decided that Pedro had gone berserk and was trying to kill his wife. On several occasions he was locked up until Monday morning, but the factory was so anxious to get him back that he was invariably let off as soon as court opened Monday. He always got back to work on time for his eleven-o'clock shift.

Next Pedro talked to the doctor. He admitted freely in high-flown language that it would probably be better all around if he did not drink. It was possible that from now on he would desist. But he wished it clearly understood that in his culture if your wife were unfaithful to you, you were expected to knock her around. And speaking of the Old Country, doctor, a person who did not know him so well might labor under the misapprehension that he nursed Fascistic tendencies in his bosom, and possibly this might account for the present persecution. But here slapped on the doctor's desk were citizenship papers to prove that under Pedro's shirt front beat a heart that was even fuller of patriotic and loyal emotions for the U.S.A. than under the doctor's own white coat.

As further evidence in this connection, he cited the favorable attitude of the factory toward him and his work. He laid much emphasis on the fact that despite all the persecution he had endured, he had not missed a day of work. If all the native-born Americans were as patriotic as he (and he could name several who were defective in this regard), the defense program would get along considerably faster.

The Pedros were an imaginative couple, high-strung and intense, whose cultural background made it possible for them to believe anything in the way of extraordinary influences, spying, espionage, or the Evil Eye. The factory informed the clinic that Pedro was a very valuable worker, that there was no question at all about his loyalty or his ability. He had borne the increase in working hours and the general speed-up quite well until the government had insisted on the checking and rechecking of credentials of foreign-born citizens. That had seemed to be for this particular individual the final difficulty that had touched him off. No one had found anything at all suspicious about him, but he felt that

he had been under observation, and it was more than he could bear. If people could suspect *him—Pedro!*—he could suspect them also, and he began by suspecting his wife.

All that was necessary to straighten out the Pedros was to assure them of their worth, loyalty, integrity, and truthfulness. Pedro accepted with gravity and gratitude the doctor's assurances that his patriotism was above suspicion. Mrs. Pedro accepted with equal gravity and gratitude the doctor's assurances that her virtue was above suspicion. But while they continue under the pressure and tension of the present program, they require weekly assurances from the clinic staff and a weekly opportunity to blow off steam, or abreact. That is what they have come to the clinic for to-day, and when they have been wound up again, they will run comparatively quietly for another week.

V.

These problems that follow in the wake of the present boom are being dealt with as adequately as present facilities will allow. As there are three types of problem—that of the unsupervised child, that of inadequate housing, and that of emotional stresses emphasized by practical pressure—there are also three lines along which the solutions must be developed.

For the unsupervised child, constructive supervision must be provided that will be acceptable both to children and to parents. An increase and a development of school facilities in general, including nursery schools and boarding schools, is the first step in this direction. Brookville, like most similar industrial communities, has available excellent schools, of the same type as that to which Henry Jenkins was sent. These schools lay great emphasis on mechanical training, as well as on character building. But public funds are usually necessary to assist in financing each child sent. Sometimes it is difficult—and always it is painfully time-consuming—to obtain these funds. Therefore more investigators, a general expansion of social-work facilities, are necessary to ease the strain in these overburdened communities. Many of these children whose parents are out of the home respond with alacrity to enrollment in well-run

recreational groups, such as, for instance, Girl Scouts and Boy Scouts, the Y.M.C.A. and the Y.W.C.A. These highly organized and nationally supervised groups have programs that offer interesting activities to youngsters after school hours. This sort of thing is always useful, but especially so in times like the present, when so much of the adult population is preoccupied with defense labors.

For the housing problems, a partial solution is already under way in the government housing projects. This is only a beginning, but it is certainly in the right direction. Another type of solution lies in the attempt to decentralize the populations of cities. If better transportation facilities can be set up, many families can live, like the Leskowicz', in rural areas within commuting distance of the factories. This is especially true in New England, where the distances are not great. Country living not only increases each family's ability to assist with food production—as Mrs. Leskowicz is doing with the poultry and with her own garden—but it also relieves many personal problems brought about by crowded living in cities. And furthermore it relieves to some extent the strain upon the city schools, especially in the elementary grades. When the children are old enough to need more specialized commercial or mechanical training, they also can be carried by bus to the city high schools.

For the emotional problems arising out of the multitude of stresses and strains, the various psychiatric clinics in the industrial communities are doing their best. Most of these communities have clinic facilities available now, but most of the clinics are appallingly rushed. The doctor in Brookville, for instance, frequently had as many as sixteen interviews a day last year, when most psychiatrists think six to eight are all that should be undertaken. The psychologist often made four studies a day, knowing that far more satisfactory work can be done on two. And the social worker's time was equally chopped up and overfull. The active clinics show a marked increase in applications. A 20 per cent increase in the past year is not uncommon, and the case load is so heavy now that it is always necessary to decide what there is time to do for each case, rather than what one would do if one had time. Under such pressure, it is almost never

possible to find time for painstaking psychiatric treatment. Every clinic day left the doctor feeling that some of the children he had seen ought to return at short regular intervals for careful psychotherapy, but time could seldom be found.

During the past year more time has been alloted to useful workers like Pedro, who could often be kept on the job if the doctor could find a half hour a week to listen sympathetically to their troubles. In many types of family situation, practical help of one sort or another can be given on an increasing scale by the social worker. Help with family relationships, help in planning for the care of chronic invalided relations, help with the budget and with a thousand other things, are all part of the social worker's activities. Thus, through the combined activities of the clinic staff, many worries can be alleviated and the patients freed emotionally from their overwhelming anxiety, so that they can get on with their work in the defense program. And this, of course—returning workers to their jobs and keeping them going—is the primary contribution of the community clinic to the defense program.

THE MORALS OF YOUTH IN WAR TIME *

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SOCIOLOGISTS would agree that the last quarter of a century has witnessed a gradual weakening of the moral fiber of family and community life. Some of the forces that have contributed to this result are expanding industrialization and urbanization; the discouragements that followed the first World War; the Prohibition era, with its wholesale evasions of law; the growth of cheap commercialized recreations that cater to the lowest tastes and impulses; the recent industrial depression, with its resulting extensive unemployment; and the increasing mobility of the population which has prevented the striking of roots in neighborhood life. It is difficult to draw the line between cause and effect, but at least one must record the increasing divorce rate; the rise in drinking, with its consequent lowering of inhibitions; the weakening of family ties; and the growing antagonism between youth and their elders. All these conditions have contributed to the deep insecurity, uncertainty, and frustration of "modern youth" in their personal and social relationships.

Into this setting has been thrust preparation for total war. Standing on the brink of cataclysm, forced to prepare hurriedly and unexpectedly for this emergency under circumstances of great stress, we have scarcely had a chance as yet even to consider the fact that young people are not too well prepared to meet some of the most crucial problems with which they will inevitably be faced. Although some religious leaders, social workers, teachers, parents, and others have on occasion shaken their heads in despair over the excessive drinking, the immodesty, and the other symptoms of lack of self-discipline in young people, and have been deeply concerned over their cynicism about marriage and family life, all too many have avoided the issue by an easy escape into

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pronouncements of "confidence" in this young generation, in a blind conviction that they are no worse after all than their forefathers, that each generation has to sow its wild oats, and that young people to-day have greater knowledge of, and much better equipment for coping with, the problems of living than the previous generation. This is the era of *Problem Parents* and *Bringing Up Father,* the implication being that young people have greater wisdom than their elders.

Are our young people ready to meet the problems that face them in a world at war?

Over a million young men are now in various branches of our military service, thousands of them being concentrated in single areas, some near large cities, others in rural districts. Most of them, new to military life—and many new even to any kind of group life—are being faced with the necessity of making personal and social adjustments that they have never before been called upon to make. This abnormal circumstance, superimposed upon the already complex psychological environment from which they have come, necessarily creates a great many difficulties for them and for the military and naval authorities, not the least of which pertains to the maintenance of their physical and mental well-being.

It is obvious that when young men live together in large groups, there is bound to be created an abnormal desire for the companionship of women which, if not gratified in wholesome ways, may lead to sexual excesses in which many would not otherwise indulge. Officials recognize this problem, and a great effort is being made to meet it through the adequate provision of recreational facilities that make it possible for boys in camps or in defense industries to meet girls and women under decent circumstances. More will be said about this later.

Meanwhile let us consider the measures now being taken to insure that aspect of the physical well-being of the armed forces which has to do with protecting them from venereal infections, and which involves tacit recognition of the fact that youths living under the unusual conditions of life in encampments and around defense industries may unwittingly,

in their urge for sexual satisfaction, expose themselves to venereal disease. *Our concern here is not, it should be said, with the program for reducing the incidence of venereal infections, but with certain possible incidental effects of this program on the morals of youth in a period when unrestrained self-indulgence, already a way of life among some, may now, during stress of war, become more widespread.*

Great lessons have been learned from the first World War, when venereal diseases were not so well controlled, the resultant effects of official negligence being felt for many years afterwards. Now army and navy medical officers are not leaving a stone unturned to prevent the spread of venereal infections. The supposition behind all this, of course, is that many youths in encampments and defense areas are likely to expose themselves to venereal diseases and are, therefore, in need of guidance and advice. Not only is this being given them, but they are also being furnished, upon request, with prophylactic materials, and are being instructed in the proper methods of using them. At no time has such extensive knowledge been provided young men (most of whom are unmarried) not only as to measures for reducing the danger of venereal infection, but indirectly as to methods of controlling conception. Most army posts and navy ship and shore stations have prophylactic materials which they either sell at small cost or furnish free to their personnel. While it should be stressed that army and navy authorities are not teaching contraceptive methods as such, nevertheless, indirectly, in connection with the program for preventing the spread of venereal infection, some contraceptive information has to be given.

In addition to this, soldiers and sailors are being warned to avoid the prostitutes and "pick-ups" who always cluster like flies around military camps, and legislation has recently been passed (H.R. 2475) making prostitution a federal offense within prescribed zones around encampments.

All of us who are sincerely interested in social welfare must heartily approve this large-scale concern for the health of youth. But we must recognize that it is indirectly creating another problem for an already much puzzled, disillusioned,

and insecure generation—a problem just as serious in its implications as the one that is being so capably attacked by public-health experts:

Given complete information about and instructions in the use of methods of controlling the spread of venereal infection, and indirectly some contraceptive knowledge, plus easy access to prophylactic materials, accompanied by severe warnings to avoid prostitutes, where, the question must be asked, are these youths finding their sexual outlets, and whose concern is it, if any one's? To suppose that they are avoiding contact is to be naïve in the extreme, and obviously the army and navy authorities are not making any such assumption.

It seems to be generally agreed that during the last war soldiers and sailors sought and found sexual outlets largely among prostitutes and "pick-ups," girls of the underprivileged classes who would congregate in parks, in restaurants, on the streets, and in the immediate neighborhood of encampments. Though not necessarily prostitutes, these young women were promiscuous, and whether because of sheer ignorance, low mentality, lack of supervision, desire for excitement, or strong sexual urge, they fell an easy prey to soldiers and sailors seeking this kind of companionship.

The problem then was at any rate more limited in scope, because at that time sex taboos were much stronger than they are now, and the moral tone of family and community life was sturdier than it now is.

As it is impossible to obtain reliable statistics on the question where the men in encampments and defense industries are finding sexual outlets—though such bits of information as we have, scattered as they are, are already causing real concern to social workers and others—we may assume for present purposes that the situation is not yet critical. But it would be ostrichlike indeed to ignore the fact that young people are likely in this time of stress to yield more freely to their instinctual urges for attention and affection through satisfaction of the sex impulse, a satisfaction now made reasonably safe from the dire results of venereal infection and illicit parenthood through the added knowledge that has

been placed at their disposal because of the urgent need for controlling venereal infection among those in encampments and defense areas.

Let us dismiss from consideration, for the moment, those youths who resort to prostitutes or "pick-ups"—girls who make vice a profession or an avocation—or to the underprivileged girl who is fascinated by the man in uniform and who seeks his companionship in cheap restaurants, in cafés, in dance halls. Promiscuity of this character can be controlled by police and welfare workers, if adequate laws exist for licensing and supervising drinking places, for the policing of streets and parks, for vigilance in hotels, roadhouses, and roadside camps, and primarily, for hunting down the racketeers who live on the proceeds of prostitution and its attendant evils. Many effective measures for the control of this kind of sexual irregularity are being considered now by the Division of Legal and Social Protection of the Federal Security Agency.[1] During the last war, excellent work of this kind was done, and it can be—and is already being—revived through various state and local committees and organizations. This is an aspect of the problem of the protection of youth from sex vice on which a grip can be taken because it is so obvious.

But our deepest concern must be for the youth who has not before submitted to his sexual impulses and for the girl who, despite increasing temptations to sexual looseness—engendered by the freer relations between the sexes, by weaker family ties, by overstimulation of the sex urge through suggestive movies, novels, excessive drinking, and many other factors—has nevertheless kept her poise and not succumbed.

Given the vast new knowledge of methods for safeguarding themselves from infection and illicit parenthood—together with the war-time hysteria that throws inhibition to the winds and causes even the adult community to excuse such transgressions more readily than it would in normal times—what, except great self-discipline, a strong idealism, and a desire to preserve the sanctity of family life, is to prevent young people from succumbing to easy temptation? The opportuni-

[1] See "The Vice Problem and Defense," by Bascom Johnson. *The Survey*, Vol. 77, pp. 140–3, May, 1941.

ties for self-indulgence are legion, and anonymity is provided by the automobile, the roadhouse, the tourist camp, the cheap hotel, and the rooming house.

This problem is not so easy to cope with as that of the prostitute, the "pick-up," and the youth who deliberately seeks to indulge himself with girls and women of this type. For among young people there has been a growing conviction that life is cruel, uncertain, insecure, puzzling—and "why not live while we can?" This is so on every social level, although among the less educated, contagion of ideas plays more of a rôle than any sophisticated conviction. An unthinking hedonism is the philosophy of the times, and youth has readily fallen prey to it.

Our task as youth leaders is to recognize that a grave danger exists and to set in motion every means of combating it. Unless we apply the brakes to the philosophy of despair which encourages youth to self-indulgence and to "escapes" from reality, the well-being of the next generation will be damaged beyond repair because it will be reared to an even greater extent than the present generation in an atmosphere of self-indulgence. The deep psychological effects of this on a family life already weakened by the stress and strain of the past quarter century can hardly be overemphasized.

Solutions do not lie in the direction of less knowledge and greater repression. On the contrary, the time has come for a frank airing of the issues, and for a concerted effort on the part of all who guide youth to help them to use their increased knowledge with intelligence; to fortify them with strength to resist the many temptations that beset them; and, most important of all, to render real and vital the positive ideals upon which we want them to shape their lives.

Any program designed to cope with this very urgent situation not only must take into account the immediate need for finding all reasonable means to assist young people in sublimating their sexual impulses, but also—and this is more basic—must give them an understanding of the positive ideals underlying successful family life, so that they will grasp the necessity for avoiding misuse of their instinctual drives.

The first of these two approaches is by far the easiest,

even though it calls for much effort and vast funds. Already, both privately and publicly sponsored programs are being organized to absorb the energies and the leisure time of youth in and around the training camps and the defense industries. Recreational programs are being arranged, and interest in these on the part of all elements of the community is great. Helping hands are being extended from every direction to sponsor, furnish, and arrange these programs, and soon there should be a vast network of wholesome recreational facilities for the proper absorption of leisure time. Correlative with this, action is being taken not only to reduce prostitution and decrease opportunities for "pick-up" alliances, but also to control more effectively the sale of liquor to minors, to provide chaperones in public dance halls, and to arrange for groups of girls of all social strata to dance with soldiers and sailors at chaperoned parties.

Much needs to be done toward eliminating the use of roadside camps for purposes of illicit sex relationships. The same holds true of hotels and rooming houses, even of trailers and automobiles. But it is not enough merely to drive these activities under cover. Prostitution itself has in these last few years, because of police vigilance, been driven out of "red light" districts such as existed during the last war. Now the prostitute plies her trade more subtly. She may be found in every part of a city, be it in a cheap rooming house or an expensive hotel room, in an apartment in a crowded neighborhood or in one in a fine residential district. She no longer needs to pick up her customers on the streets. They are brought to her by taxi drivers and others to whom she has made known her whereabouts. All of this illustrates the fact that although pressure may be applied from above to eliminate vicious conditions, they will continue to exist, even though not so obviously or extremely, until an aroused public shouts for their elimination. Not too much can be expected from repressive measures, unless hand in hand with them goes an earnest desire to raise the moral "climate" of social life.

A more important approach to the problem is, however, a long-time educational program in which all youth leaders must participate, designed to arouse girls and boys to the

need for preparing themselves adequately for family life and for the responsibilities of parenthood. Youth must be made to understand the psychological and spiritual damage they do to themselves, and to the children whom they will one day have, if they approach marriage via the route of promiscuity and self-indulgence.

The time has arrived for carefully guided discussion about this problem among young people, their parents, their teachers, and others who are in authority over them. It is obvious that youth does not respond to moral preachments and that new techniques of education and persuasion will have to be found. Skillfully prepared radio programs, magazine articles, forums—all of which would be concerned with a strengthening of the faith of young people in wholesome marriage and parenthood—would probably have a salutary effect. School and college courses on preparation for family life, programs of marriage counseling, and similar channels for meeting this problem should all be encouraged. Although some beginnings in this direction have been made here and there by schools, colleges, social-hygiene societies, and like organizations, the need is still very great. It is of particular importance to reach by such programs boys and girls under sixteen years of age, so that by the time they are faced with the problems with which the somewhat older group is confronted to-day, they will be ready to meet them without the sense of confusion and inadequacy that many young people now have.

Basically, the need is for strengthening the moral climate of the times and for re-weaving into the fabric of community life a faith in the homely virtues. Unless we do this, we cannot hope to turn the rising tide of self-indulgence, or to avoid the dangerous flotsam and jetsam that follow in its wake.

Religious leaders, teachers, parents, social workers, psychiatrists, and all others who guide youth must pool their knowledge and resources and direct them toward finding solutions to this problem. *The very basis of family life is being threatened as never before, and no effort is too great to make toward its preservation.*

PSYCHOLOGICAL MATURITY AS A BASIS FOR DEMOCRACY

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THE fourth chapter of the book of Genesis recounts how Cain was angry because the Lord had not respect for his offering, whereas the offering of Cain's younger brother Abel had been respected. "And the Lord said unto Cain, Why art thou wroth? and why is thy countenance fallen? If thou doest well, shalt thou not be accepted?"

If Cain had found it possible to answer this question in the affirmative, he would not have slain Abel. If society in the past had been able to answer the question with a "yes," it would have been less of an arena for power struggles and better adapted to the recognition of individual needs and responsibilities. If we are to progress in our own democracy, this question put to Cain must be effectively answered.

There are two important concepts to be found in this story of Cain: the first is that despair and anger come when one is not accepted, whether one be the individual or the outcast tribe or nation; the second is that if one does a job well, to one's own satisfaction, one *will* be accepted. This is perhaps the hardest lesson in all life to be learned.

One could cite numberless examples in history and art of the story of Cain, examples of men and women who suppressed their antagonism toward their younger brothers, and instances also of those who, like Jacob, competed for the birthrights of their elder brothers. The experience of almost every one illuminates the fear and anger of older children when they must share the affection of their parents with newcomers, with upstarts, with people who express their wants without restraint. We know from family histories, too, the story of these invaders, these younger children who feel that some one has been ahead of them in harvesting affection.

These are the seeds of the combat for power, the constant pressure to send out tendrils to encompass parental affection

and to find sustenance in parental praise. In the place of parents, it is a short transfer to seek this same assurance of regard and strength from elders, who speak for the departed spirits and the gods, and from them to the magician and the priestly orders and those authorities which became the state. "The wrath of a King is as messengers of death; but a wise man will pacify it. In the light of the King's countenance is life; and his favor is as a cloud of the latter rain." From the purchase of a birthright blessing for a mess of pottage or a venison stew, it is an easy transition to substitute the assurance of money for that of an affectionate word, to manipulate one's own life for wealth and the power of wealth in place of parental reward. A replica of this pattern is to be found in the courtier or official who became strong through his sovereign's blessing and very literally impotent when the sovereign's curse removed his head. We see the blessing of the state in the grant of powers, offices, monopolies, immunities; we know its frown in the form of legal sanctions, outlawry, forfeitures.

Before leaving the stories of Cain and Abel and Jacob and Esau, we should notice another component feature of both—that is, the sense of guilt of him who succeeded in his power quest. Cain in his guilt tries to hide from God; Jacob is afraid to meet Esau and sends before him rich gifts to buy his peace. In each instance, the elimination of the rival does not bring satisfaction; neither parental nor fraternal peace is secured from the triumphs of superior power of violence, purchase, or deception. There is no security when power is the aim of action. The child must forever be reassured; the adult must repeat and repeat each unsuccessful search for satisfaction; the rich man must multiply his fortune and make repeated gifts to welfare and charity, to God and to his brother Esau; the sovereign must extend his rule and gain the last syllable of recognition; the dictator must make the crescendo of his triumphs faster and bolder.

Suppose Cain had thought, "After all, my bent is agriculture, Abel's is sheep raising; there is a place for both of us," would that not have been a greater security for him than the feeling that he must measure differences against a fan-

tasy of acceptance? Men strain for security, but have they ever found it in aggressive competition or in a failure to accept differentiation as in itself no *threat?* For if the attempt to find security is made through aggressive competition, then the only good Indian is a dead Indian, and your own scalp is in issue. And if the fact of variation becomes a threat to you—if it arouses fantasies to satisfy your own real or imagined failures—then the sword must be forever in your hand; for if you be a man, you will resent woman, and if a woman, you will resent man; if you be of the majority in faith or race, you will fear the minority, and vice versa; he who deviates from you will enter into every sentence in your mind, every desire of your heart, like King Charles's head. "He is different; therefore he must have something on me," can be the road to the asylum, the motto of perennial immaturity, or the poison of society.

Concurrently with the drive to power, with the aggressive urge to competition, we find the longing for those moments of experience, sometimes half submerged in the subconscious, seemingly a dream, in which the ideal of no competition is realized, in which peace has been earned, or possibly bought. The pretty fantasy persists of each man living quietly under his own vine and fig tree, in his own undisturbed Eden, where no tree bears forbidden fruit and no one threatens interference. Then there will be a great brotherhood of all mankind. David and Jonathan will be as brothers. David, the little fellow who slew the overpowering and threatening giant, and Jonathan, the king's son, will live in peace and brotherly love. The statesman longs to return to his law office, the industrialist to his farm or science laboratory—if only he can get release from his obligations—obligations imposed in large measure by his own seeking for power satisfaction, burdens that appear to him to be in conflict with non-competitive contentment. This is not to say that the statesman or the industrialist cannot find satisfaction in his work and contentment in his play. But it must be work and play that in themselves are media for the expression of personal interest and the exercise of personal capacities, not merely evidence, to the world and to the individual himself, of his increasing or continued potency. Here is no Utopia, no

heaven on earth where men play harps or skittles and women sing like the angels and purr like kittens.

It is the transitory nature of the satisfaction we get from power and glory and the momentary assuagement of blood lust that requires of those who are insecure in themselves and in their relations with others the reiteration of cruelty. It is such emotional insecurity that keeps the world stirred up. This is not that economic insecurity on which the Marxists pin their faith, for Crœsus himself and the most redoubtable and economically secure capitalists have generally been unable to desist from the struggle for greater wealth and power. The manufacturer must expand his plant; the banker must move to control the industries he finances and, where he can, the government whose bonds he buys and whose notes he discounts. Always they measure themselves against possible competitors and enemies and, fearing eclipse, must push on toward monopoly and complete control, demons more unattainable than any god.

If the only choice of mankind lay between the Utopian dream and the fight for power, there would remain no vestige of hope for maturity, no scintilla of expectation for civilization. But the fact is that individual men and women do become mature, and a third alternative for social man exists in the hypothesis that a substantial part of mankind can become mature enough to recognize the fallacy both of the compulsive struggle for power and of the fantasy of Arcadian bliss, the fallacy that satisfaction can be achieved by aggression and destruction on the one hand and, on the other, that everything can be got for nothing. There is hope in the hypothesis that, once men recognize the way to maturity, there will be a sufficient number of them ready to pursue that way to colonize and expand the new world.

This hope long ago was translated into basic ethical doctrine. It is the core of the concept of brotherly love, of brotherly equality as against fraternal competition. It is the heart of the admonition to love they neighbor as thyself, in contrast to fearing that in difference there lies danger and competitive destruction. (As Paul wrote to the Galatians, "Thou shalt love thy neighbor as thyself. But if ye bite and devour one another, take heed that ye be not consumed one

of another.'') In this hope of maturity is the seed of the program to do unto others as you would have them do to you instead of attempting to acquire power over them. It is the impulse that leads to the social objective of requiring from each man according to his ability and rendering to each according to his need, as contrasted with getting what you can, when you can, while the getting's good.

The ethical pattern of family life is not competitive. When it is, there is discord in the family. Instead of competing, we grant to each member of the family according to his needs and ask from each according to his ability. The breadwinner does not eat all the bread because he earns it, or because he has greater strength or holds the purse strings. The core of what we know as civilization is in the increasing achievement of this pattern of shared equality in family life and its extension to other social connections. The family relationship to property is far more than an equality of property rights or even than a community interest in property. As a matter of law, neither such equality nor such community interest may exist. But it is an ethical and a psychological attitude which grants respect for the weaker members and their needs and shares responsibility among the members in accordance with their capacities. It is a fellowship and not a prison or a prize ring.

The problem of democratic living is not greatly different from the problem of good family life. It cannot be based on terror or greed, on cruelty or selfishness, if the several members are to develop their capacities and not be hampered by a sense of impending threat or illusions of personal impotence. Children do not mature in such an atmosphere nor do parents realize the fullness of their maturity. In the good home there develops mutual respect and understanding, not identity either of interest or behavior or capacity or belief, or even of need and satisfaction. In the good society, the happy state, there need not be, nor can there be expected to be, such identity among the members.

In the well-adjusted home, there is an ever-expanding equality as the younger members mature, a willingness to share and contribute to the group welfare, a readiness to yield authority and grant independence to the adolescent

members, instead of keeping them subordinate as a symbol of parental authority. Its standards of satisfaction are phrased in terms not of "What can I get?" but rather of "What can I do?" Ethical well-being is not *parallel* to, but rather *identical* with, psychological well-being.

We know that as the child struggles to be accepted as a part of the family group, he is at the same time struggling to be recognized as different from the family group. The son likes to look like father, but in the same breath he wishes that his aunts would say that he is also stronger and bigger. The daughter likes to be told that her voice is like her mother's, but she longs to be more beautiful and socially more competent. These urges are not stilled even by the knowledge that a time will come when the son's strength will exceed his father's, the daughter's beauty her mother's. With adolescence the need to show one's own capacity develops with increasing force; one doesn't want to be the Johnsons' little boy or girl or even big boy or girl—one wants to be Dick Johnson or Anna Johnson. One wants to achieve the interest of others in one's self, not just in a member of the Johnson family. If recognition of this individuality is denied by parents, the adolescent becomes aggressive or passive; his development is distorted.

Beyond family and clan, men have other social relationships—in occupation, recreation, religious observance, and political life. In such relationships, they may be competitive and seek preferment, or they may ask only that their individualities, their capacities and interests and needs, be not glossed over, but noticed with a sympathetic interest. They want to talk about their jobs, their childhood, their families, their health, their opinions, and the little things that they have observed and what they said then and thereafter:

> "Around my fire an evening group to draw,
> And tell of all I felt, and all I saw."

It is here that society has failed. It has not adequately afforded men and women, and young people in particular, such recognition. When the fluid mass of factory workers, typists, and salesgirls succeeded the apprentice, the journeyman, and the clerk, the relationship to master and owner

was changed. Profit replaced livelihood as the purpose of production and commerce. Money-making became an end in itself, abstracted from the aim of making a living. Little was left in the way of normal, healthy recognition of the worker.

Political life has also reflected the depersonalization of institutions. The triumph of the royal court over feudalism involved the abrogation of most requirements of service by the tenant to his immediate overlord and of protection by that overlord of his tenant. The place of labor and produce rendered to the overlord was taken by cash rents and by taxes collected in the name of that distant and unfamiliar enthroned overlord, the King.

The Puritan and the French revolutions tended to personalize government again. You might not be a part of government, but some fellows *like* you who *didn't* wear silk pants were in the seats of the mighty. If you were a French peasant, you got the sense that the Revolution recognized that you were a man; you could now work for yourself, and need not slave for the aloof father on the throne and the support of his pompadoured women and crystal chandeliers and absentee landlords. If you were a British tradesman, you had the sense that the new government and the new principles of government recognized your personal needs. The American Revolution was among other things a resistance to the tendency to depersonalize the frontiers and to make the merchant jump to tunes piped three thousand miles away.

The very words, "All men are created equal," "Liberty, Equality, Fraternity," and the British policy of protecting a Britain with guns, if need be, in any part of the world, caused men to feel that they were accepted; they were a part of the government; it was theirs; they were not to be dependent or treated as unruly children.

It is not, then, merely the struggle for power and for the distribution of the weapons of power that explains the internal and the external conflicts of nations. It is not simply the reaction to an unequal diffusion of economic security, of goods and opportunities, that brings about attempts to read-

just the balance, the reforming and revolutionary periods of history. These struggles and attempts at readjustment are symptoms; they hark back to motivations familiar to us all. We can see the elements of this design in competitive family life; and in family life we can also discover a blueprint for the achievement of satisfaction.

It would appear, then, that as the *ethical* concepts of society place man in social relationships that involve social responsibilities, they concur with those *psychological* factors which are involved in maturity.

To do a job well for the satisfaction of the self-realization involved or because it makes possible the satisfaction of other needs in various relationships, to carry on satisfactory relationships of reciprocity with family, friends, and acquaintances—these are the aims of the good life, whether framed in terms of psychological maturity or of ethical principles or paraphrased in terms of democracy. But ethical ends tend to be garbled and psychological growth squeezed out where competition is the keynote, where the drive is to beat up or beat out some one else.

It would follow that ethical ends cannot be attained without the recognition of their psychological components and without a program that proceeds toward aiding more and more people to achieve emotional and intellectual maturity.

Those processes which we call democratic are not ends in themselves, any more than engines and ships are ends in themselves. They must be used if their meaning is to be realized. These processes can be used for socially destructive or for socially creative and moral ends. To achieve the latter requires a people that is socially creative and that is motivated by ethical purposes. It seems to me that the development of such a people demands an even greater assimilation of the discoveries of psychology into the educational process. And this does not mean that the subject matter of education in the elementary and secondary levels should incorporate psychology, or that the methods should be those that make learning more effective; it means that education should pay greater attention to basic psychological attitudes and drives.

It is here that the guidance bureau must perform an import-

ant function in training teachers and in developing techniques that will bring forth creative and ethical attitudes in young people. Teaching them to be successful, holding up power as a virtue and aggressive competition as a way to live, laying down to the law—these methods have not worked. The needs of a peaceful world and of a democratic and moral society—a happy land, if you will—require an educational system that will be conscious of psychological motivation and that will have the purpose of developing mature people with moral ends.

I believe that the next developments in education will come not from philosophy and pedagogy, but from psychology—the science of human minds and emotions.

IDEALS AND PRINCIPLES FOR PROPER MANAGEMENT OF THE MENTALLY ILL *

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IN striving to meet the needs of its mentally ill, the state must answer several fundamental philosophical questions. What does it envisage for its people? Does it accept their needs as its guide? Their needs are the needs of any people who are attempting to live satisfactory lives. The way in which they are treated is a reflection of the keenness of the state's feeling for all its people, which means, in a democracy, the feeling of people for one another.

First of all, there is the need to live—a physiological need; next, there is the need to live happily—a psychological need; and third, there is the need to live happily and productively—a social need. These are the needs that a state should be concerned about for all its people—sick or well, young or old.

But with certain of its people who are handicapped, the meeting of these needs requires special effort. These people are far from being happy and productive; their lives may even be threatened. Does the state go on the principle that certain of its people are chaff—not worthy of its concern, derelicts? We recognize the danger of such a principle, for it is apt to prove a boomerang. It fosters a callousness; it obscures the conditions that have produced such problems.

This is particularly true of the mentally ill. Popular opinion has it that the insane are dangerous. A few of these mentally ill are a danger to other people. We know that it is the very exceptional case that is to be feared, but none the less the state has a function to perform in protecting the public. Far more of the mentally ill are aggressively dangerous to themselves. For these, too, the state has a responsibility, and it must see that no harm comes to them. The rest

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are in difficulty chiefly because they cannot fend for themselves. They cannot compete with their normal fellows; they get into trouble with other people; they squander their resources; and so the state must give them guardianship.

In protecting the sick person himself, in exercising guardianship, the state is dealing with one of the most cherished possessions in a democracy—freedom—and every effort must be made to insure not only that this is not dealt with lightly, but that it is not dealt with in a way that does further injury to the patient. We have, in other words, a combination of legal and medical issues in the restriction of the patient's freedom that demands a high quality of psychiatric judgment. The commitment laws of the state must at best be a compromise, in order that the legal formalities may not be detrimental to the patient and in order that the professional judgment may be surrounded with legal safeguards. Model commitment laws do just this. These laws are dealt with in a pamphlet prepared by Dr. Grover A. Kempf, and issued by the United States Public Health Service.

The subjection of the mentally ill to a procedure that is based on criminal practice is doubly bad. On the one hand, it stigmatizes and injures the patient, it delays his treatment, and it handicaps his physician from the start. Trial by jury, charges, pleas of guilt or of innocence, arrests, custody by police rather than by health officials, all contribute to this criminal atmosphere. On the other hand, the habeas corpus proceeding not attuned to this civil process provides no safeguard to the public. The paranoic may easily escape detention and become a public problem.

The enlightened procedure in effect in some communities for handling juvenile delinquents by civil and highly professional process is in spirit in marked contrast to the procedure for dealing with the mentally ill. The mentally ill need the simplest form of commitment possible; they need limited commitments for observation; they need voluntary admission for those who wish it. This is not merely a question of law, but also a matter of making voluntary admission attractive, of providing a good reception service.

Many of these sick children of the state can be restored to health, and so the responsibility of the state is one not merely of protection, but of treatment and of return to happy, pro-

ductive living. Again, many of these persons could have been saved from breakdown had the conditions that were generally known to those about them been changed. Every one of these patients points from his hospital back into his community—to conditions in his home, in his employment, in his school, in his avocational life, to his doctor, and to his church. He points to things that might have been done that were not done. And since he is pointing them out, the state has a responsibility for attending to his pointings, for doing something about these conditions that presage break.

These possibilities for prevention can easily be sensed in the course of good psychiatric treatment of the developed case. What is good treatment? First of all, it is prompt treatment. It is extremely wasteful of professional effort, of possibilities of getting at causes, and of chances of recovery for the sick person, to allow a condition to persist untreated in its early stages. Early treatment is, however, only partly insured by the provision of adequate resources for the treatment of the mentally ill by the state. To a large extent it depends also upon the attitude of the public toward mental illness—the attitude that makes the family hide a mental breakdown until it becomes so pronounced that it is impossible to hide it any longer; the attitude of the hospital administrator who objects to voluntary admission of patients because voluntary patients, as a special class, increase his administrative problems; the attitude that looks upon the provision of extramural service by a hospital as a frill rather than a fundamental, or that regards a disturbance caused by a psychiatric patient in the community as a police rather than a medical problem.

Secondly, good treatment means decent surroundings. It means humane care with individual attention rather than mechanical restraint as a way of saving money on attendants. It means the same courtesy toward the mentally ill that would be given to the diabetic in a general hospital. Constraint is frequently unavoidable. The attendant, the nurse, or the doctor may have to make decisions for the patient, but this is a professional service to a respectable citizen and should never be allowed to give rise to the belief that the patient deserves disparaging, tactless, or unfeeling words and actions by those in whose charge he is placed.

As long as any one with such an attitude remains on a hospital staff, how little can be expected of the general public attitude toward the mentally ill!

It is to be presumed that all of us in the community have somewhat stronger resources for meeting the ordinary pressures of life than has a patient who has broken down mentally. Think of yourselves, then, as being housed in such a way that day in and day out you are forced to live in inescapable proximity to other persons not only with whom you have nothing in common, but about whom you may have fears, suspicions, or disgusts. All of us are the better for being able to enjoy solitude once in a while. How much more heavily inescapable contact must bear down upon at least those of the mentally sick who have not entirely escaped reality! They are, to begin with, mentally sick in part because of their high sensitivity. No one, so far as I know, has any satisfactory solution to offer for this problem, but some seem completely to ignore its existence. Perhaps for the present the best that we can do is to keep in mind that it is a problem and to attempt to compensate for some of the distressing aspects of overcrowding. It seems that at best the situation for the patient is serious from that standpoint.

The third need of the mentally ill is good food. They require better food than the mentally well, who have a degree of resilience. Food serves two purposes. Its simplest value is to maintain the body economy. The incidence of pellagra in many hospitals is sufficient evidence of inadequate attention to this need of patients. But food serves also as a more deeply meaningful tie between the person and his environment. To the child at birth, it is almost the only tie. To the adolescent leaving home for the first time, there are often qualms about the adequacy of food derived from other sources than home. The Hawaiian craves his poi. Others crave their black-bean soap and their salt pork because they have a deep emotional tie to these things. Again and again the gastrointestinal disorders of young people are traceable to the period of transition from eating at home to eating elsewhere.

It is to be expected that among the mentally ill these emancipations about food will be less complete than they are with the average population, and that many upsets will inevitably

occur if this significance of food is not taken into account. How much greater the upset of the mentally sick if the service of food, the preparation of food, and the types of food offered in a mental hospital are disturbing to us as we visit the kitchens or dining rooms! How difficult it is for the psychiatrist to struggle against such handicaps in his effort to do his best for his patients! In the patient's mind, the psychiatrist becomes one with the system that creates these unpleasant conditions.

The fourth need of the mentally ill is for good medical and surgical care. A hospital is a sizable community, a crowded community, a community of weakened persons often unable to reveal promptly their need for the treatment of bodily disorders. Often their mental disorders are due to, stirred up by, and exaggerated by bodily illness; and, conversely, their mental disability often produces or exaggerates mental and surgical problems. There is a demand for unceasing vigilance if these problems are to be dealt with.

A hospital may be fairly prepared to deal with fractures or other medical or surgical emergencies and at the same time be quite lacking in alertness to, and facilitates for dealing with, the less pressing dental conditions, incipient tuberculous disorders, and other less obtrusive illnesses. These may be allowed to drift along, often threatening the health of other patients, until they become themselves an inescapable emergency.

A mental hospital needs all of the facilities that characterize the modern general hospital. Pneumonias are very common, along with all of the other physical disorders of older people, and unless the state takes the attitude that these of its children are less important than others, it must be unusually alert to the medical and surgical problems of the mentally ill.

The fifth requirement for adequate service to the mentally ill is good psychiatry. There is no escaping the fact that this costs money. The superintendent of a hospital has to correlate all the aspects of living of the patients. As an assistant at his right hand, there is need for a first-class psychiatrist who can act as clinical director; who can evaluate the psychiatric work of the staff; who can act as a mentor for the younger physician; who can keep an eye on the scien-

tific literature, incorporate advances into the processes of the hospital, and see that the staff does likewise; and who can keep before the staff the unknowns in the field, in order that they may not be complacent about their deficiencies. Such a man should be no less qualified than the assistant professor of psychiatry in a medical school and his functions are not too dissimilar. These functions are so important that those who exercise them should be looked upon as a main source of supply of teachers of psychiatry for medical schools. The tone of the medical care of the patient is fixed by the person who holds this position, for often, even in overcrowded hospitals with limited staff, it will be found that high-grade work is being done by each psychiatrist on carefully selected patients because this scientific leadership exists in the hospital. The same is true all the way through the nursing staff.

The sixth component of good treatment for a patient is adequate facilities for occupation and recreation. These functions in the life of a patient are about the only things in our hospitals for the mentally ill that have possibilities of capturing and holding his interest over a period of time, and it is this capturing and holding of interest that we should take seriously if we hope for a reintegration of the personality. Integration merely means that in his behavior a person mobilizes all of his forces toward the goal of his effort. Few, if any, of us are entirely integrated in this respect. We have our qualms about things that we do, and we have mixed feelings. This unity of thinking and action is greatly enhanced, however, if, as we go along through life, our various experiences are reconciled with one another and pointed up harmoniously toward the things in which we are interested. The patient who has an interest in occupation or recreation has something to which to tie his daily experiences, including his psychiatric treatment.

Our most outstanding example of this is the man who, in the course of his psychosis, developed an interest in the lot of his fellow patients and in starting a program for their protection and the improvement of their treatment. From that time on, he kept this goal in mind and related all of his daily experiences to it. This brought about a reintegration

that expressed itself in his founding and leading of the mental-hygiene movement. This idea of starting a movement for the protection of patients was Clifford Beers's occupational therapy and recreation combined.

Occupations and recreations are not merely ways of passing the time away during a period of enforced hospitalization. They are rather threads dangled in a concentrated solution of confused human experience in order that this experience may crystallize about them and take useful forms.

Virginia, the state in which we are meeting to-day, has among her two and a half million citizens some 12,000 who need her special mothering. Let us for the moment, however, forget this number. Let us think of just one of these citizens. What were his potentialities as a child? What caused these potentialities to be lost? What problems did he create in his home and in his community? What disadvantages and delays did he experience in getting to the hospital? Were formalities and cruelties of court procedure a deterrent to early treatment? Did the public attitude toward mental illness delay his family's admission of the seriousness of his difficulty? What does he need to get well? What does he need to get back to his community? What does he need to stay well? What support, material and moral, does his family need in his absence? See how complex this one case is. See how it points to public education, public health, local clinical services, local hospital services, court procedure, public opinion, therapeutic facilities in a mental hospital, social service in preventive clinical work.

Now multiply the complexities of this one case by 12,000, and what have you? Still only a part of the total picture. Add to that part those who have been discharged from the hospital; the out-patients in the community; the neurotic patient in the general hospital whose case is obscured by gastrointestinal, gynecological, neurological, and other complaints; the partially incapacitated, who make up much of the dependent population, who are only half living and half working. Add these four groups, the out-patients, the discharged patients, the neurotic, the dependent—whatever their numbers may be; we have not yet counted them—to the 12,000. Then take the 2,500 mental defectives who are in

institutions. Multiply these by ten, and you will have a very conservative count of the mentally defective in the state. The failures in the classroom, the failures in industry, the partial failures on the farm, and those who are hidden in the back rooms of many homes—add all these to the 12,000 and then you will have a truer figure by which to multiply this complex single case.

There are certain things that only money will buy—food, adequate medicines, adequate facilities for the treatment of patients, including uncrowded quarters and good staff. But there are many things that are not dependent upon money. In fact, some of them cannot be bought. One of these is freedom from political interference. In the long run this is really a money saver; there is nothing more hampering to a hospital than to have to employ staff who are not motivated by professional interests, whether they be carpenters or psychiatrists.

Money will not buy staff morale. There is much false economy in the failure of many hospitals to cultivate carefully the professional capacities of new staff members. For the first six months, such cultivation is costly, but the earnings on this initial investment come in over a long period of time at high rates.

Money will not buy community coöperation and understanding, but the leadership that sees beyond the mere hospitalization period—the time between the entrance and the departure of the patient—can do much for community coöperation and understanding.

Many of our commitment procedures are far more costly than is necessary. New York City has recently unburdened itself of lunacy commissions that not only served no purpose, but that cost large amounts of money to maintain. By using the facilities of Bellevue Hospital, the city is now able to do a better job at perhaps one-tenth the cost.

In so far as they are conscious of these ideals and principles, the authorities in whom the public has vested the responsibility for the care of those citizens who need the maternal protection of the state, need your support, and I am sure would welcome your critical and friendly interest.

THE SALE OF ALCOHOLIC BEVERAGES

A PROPOSAL FOR CHANGES IN THE PRESENT METHODS TO CONFORM WITH THE FEDERAL FOOD, DRUG AND COSMETIC ACT AND TO PROMOTE PUBLIC HEALTH *

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THE American public is at the present time protected against false claims, misleading advertisements, and misbranding, on the part of manufacturers and distributors of food and drugs, by the provisions of the Federal Food, Drug and Cosmetic Act.

Suppose, for example, a food is claimed to have a higher vitamin or mineral content than it actually has, or is sold as a natural product when in reality it is a dried or synthetic product, then the manufacturer may be haled before a court and prosecuted under the provisions of this act. Take another example—the case of a pharmaceutical house that puts on the market a drug of any type. If medical experience leads to the opinion that the drug may be habit-forming or that, when taken in excess, it gives rise to certain disturbing and pathological symptoms of intoxication or addiction, or if it produces mental derangement or is otherwise harmful, failure of the manufacturer to state these facts on a special warning label is viewed by the law as a misbranding of the product and brings the purveyor into sharp conflict with the provisions of the above-named act. Fine or imprisonment, or both, may result, together with the confiscation and withdrawal of the product from the market.

* Presented at the Ninety-second Annual Session of the American Medical Association, Cleveland, June 4, 1941.

Under Chapter II of the Federal Food, Drug and Cosmetic Act of 1938, we find the following definition of the terms "food" and "drug": "The term 'food' means . . . articles used for food or drink for man or other animals." "The term 'drug' means . . . articles recognized in the official United States Pharmacopœia."

Further, the Federal Food, Drug and Cosmetic Act judges an article to be misbranded when the label is misleading or "when the labeling fails to reveal facts . . . material with respect to consequences which may result from the use of the article."

The present methods of sale of alcoholic beverages appear to us to run afoul of the Federal Food, Drug and Cosmetic Act in two important respects and for several cogent reasons. First, there is no doubt that alcohol is both a food and a drug according to the criteria of the Federal Food, Drug and Cosmetic Act. It is a food because it serves as drink to man, and it is a drug because it is included in the United States Pharmacopœia. The United States Pharmacopœia includes alcohol three times: first, in general as alcohol or ethanol; second, as dehydrated alcohol (alcohol absolutum, dehydrated ethanol); and third, as alcohol diluted or diluted ethanol, which is the actual form under which it is sold as a beverage in most instances by the liquor industry.

Second, in our opinion there can be no doubt that alcohol sold in whatever form as a beverage may be habit-forming, and the textbooks of medicine list under the heading of alcoholism and alcoholic diseases a large group of disorders of the body and of the mind that are causally related to the use of alcoholic beverages, and specifically to its habit-forming and dangerous qualities.

We appreciate the fact that the term "habit-forming" is variously used and may mean anything from simple habit formation to addiction in the narcotic sense. We use the term here in its general connotation. We appreciate also the fact that certain personality types are more or less "addiction-prone," and that emotional impulses and other factors underlie or are associated with the formation of the addiction pattern. At the same time we are aware that methods of sale and distribution and other social factors as well as the

drug itself play important parts in the complex of habit formation.

How is alcohol at present sold?

It is sold as if the Federal Food, Drug and Cosmetic Act did not exist. There may be legal reasons for this evasion of the realities of the situation. We have heard conflicting opinions on the matter from eminent legal authorities. It has been said by certain learned persons who are in a position to know the attitudes of the Food and Drug Administration that there is no authority conferred by the Federal Food, Drug and Cosmetic Act of 1938 to deal with alcoholic liquors. These authorities have further stated that in the enactment of that statute, Congress was aware of the existence on the statute books of the Federal Alcohol Administration Act, which dealt particularly with alcoholic beverages, and therefore refrained from incorporating into the Federal Food, Drug and Cosmetic Act any provision that would supplant the previously enacted Federal Alcohol Administration law, which particularly covered the points of manufacture and taxation, but as particularly ignored the public-health aspects of the problem.

An equally eminent legal authority has stated to us that "unquestionably one is correct in assuming that the definitions of the Food, Drug and Cosmetic Act include whisky as a food and a drug; obviously all alcoholic beverages are foods, and furthermore, such of them as are recognized in the pharmacopœia or are indicated for use in the treatment or diagnosis of disease are drugs," which would include sherry, port, and many wines, as well as brandy, gin, and whisky. "It has also been pointed out that alcoholic liquors have been included in the definition of a food since the original act of 1906."

"It has been pointed out that the definitions in the Wheeler-Lee amendments to the Federal Trade Commission Acts are the same in these respects as in the Food, Drug and Cosmetic Act. The Commission, therefore, has jurisdiction over advertising." "It has been suggested that the Food and Drug Administration (and one may suppose the Federal Trade Commission also) have not exercised themselves about alcoholic beverages because the Federal Alcohol Administration

supposedly has exercised and still does exercise supervision over the sale, labeling, and advertising of them. Permits from the Federal Alcohol Administration are required for engaging in the liquor business."

"There is nothing in any of these several acts to operate as a repealer, the one of the other. Instead, there is an overlapping."

Naturally, we side with the opinion favorable to what we believe to be a prime social necessity—the protection of public health against misbranding and misleading advertisements of alcoholic beverages. If, on the one hand, there is no specific authority conferred upon the administrators of the Federal Food, Drug and Cosmetic Act in respect to alcohol, on the other hand *there is no exemption of alcohol from the provisions of its administration, either by anything explicit or anything implicit in the law.*

Let us consider certain specific features of the sale of alcohol and see whether or not they violate at least the spirit of the Federal Food, Drug and Cosmetic Act and—what is more important—threaten to endanger the health of the American people.

1. Every bottle of alcoholic beverage, and especially of the stronger drinks, violates the spirit, and we believe the letter, of the law—namely, the Federal Food, Drug and Cosmetic Act—in that, without so stating on the label, it contains a substance that may be habit-forming and that may bring about disastrous effects to the purchaser if unwisely used. There is no question but that the most important and the most widely used habit-forming drug of Western civilization and certainly of America is alcohol. Irrespective of what any one may claim about underlying personality problems in the chronic alcoholic addict (with which we might agree), the fact remains that without excessive indulgence in alcohol, alcoholism does not occur. And it cannot be denied that methods of advertising, sale, and distribution, as social factors, play an enormously important part in the production of alcoholism. If one placed in a heap all the wreckage of human lives produced by the habit-formation implied in morphinism, cocainism, barbiturate addiction, and all the narcotic and hypnotic drugs put together, and balanced

against them all the habit-formation of disastrous type subsumed under the term *alcoholism,* the scale would shift immediately and unmistakably toward alcoholism.

One of the innumerable studies on this matter is that of Alexander, Moore, and Leary,[1] which showed that alcohol caused not only more deaths than any other toxic substance, but more than all of them put together.

Therefore, *there can be no question that if the Federal Food, Drug and Cosmetic Act is designed to prevent—and to protect the American public and its health from the menace of—drug intoxication and addiction, alcohol, instead of being neglected and ignored altogether, is the first drug to which the act should apply.*

2. Assuming that whisky in moderation and under proper directions for its use is not harmful—and we believe this to be so—nevertheless, it remains true that he who buys whisky has a right to purchase the genuine article and not an imitation. It is our opinion—and it was Dr. Harvey Wiley's opinion, amply documented in his book[2]—that a large part of the whisky on the market to-day may be considered misbranded as a food according to the provisions of the Federal Food, Drug and Cosmetic Act. Let us examine the law in respect to the sale of whisky:

Food in particular is misbranded (1) "if its labeling is false or misleading in any particular"; (2) "if it is offered for sale in the name of another food"; (3) "if it is an imitation of another food, unless its label bears, in type of uniform size and prominence, the word 'imitation' and immediately thereafter the name of the food imitated."

In our opinion, there is no doubt that if the Federal Food, Drug and Cosmetic Act were administered to cover what it should cover—namely, the sale of alcoholic beverages—then all of the cheaper blends of whisky would violate these provisions of the act.

Under the provisions of this act, the cheaper whiskies should be called "imitation whisky" or "freshly distilled

[1] "Deaths From Poisoning; Incidence in Massachusetts," by Leo Alexander, Merrill Moore, and Timothy Leary. *Journal of Criminal Psychopathology,* Vol. 3, pp. 100–11, July, 1941.

[2] *The History of a Crime Against the Food Law,* by Harvey W. Wiley. Washington, D. C.: The author, 1929.

grain alcohol with whisky flavoring." Manufacturers admit these distinctions themselves by their own statement on the small label, discreetly placed on the back of the bottle, in which they do distinguish between the whisky and the grain-alcohol content of the beverage; whereas on the front label they call the entire beverage whisky although the grain-alcohol percentage usually predominates. Freshly distilled grain alcohol produces more severe intoxication and produces intoxication more quickly, probably because of its more rapid absorption by the intestine, possibly also because of its smaller content of acids and aldehydes; furthermore, according to MacNider's work, it causes kidney damage.[1]

Dr. Timothy Leary, of Boston, referred to these facts in a paper[2] published in 1938, and they were brought out also in a paper by one of the present authors:[3]

> "It has been demonstrated beyond doubt by Leary (1938) that most of the deaths from acute alcoholism are due to the consumption of concentrated freshly distilled grain alcohol (190 proof) and of some of the cheaper makeshift (blended) whiskies. Furthermore, MacNider (1925) was able to produce kidney damage by fresh distillates. Liver damage (cirrhosis) may result from impurities commonly found in all kinds of freshly distilled alcoholic beverages. It becomes imperative, therefore, to prohibit the sale of concentrated (95 per cent) grain alcohol (190 proof) over the counter in drug stores without a prescription, and to limit the highest concentration of alcohol sold on the free market to 95 proof. Furthermore, the public should be educated by systematic propaganda to refrain from the use of any spiritous liquor that has not been properly aged. It is equally important to educate the public to read the small label on the back of liquor bottles instead of the flashy front label. While the front label extols the virtues of an exquisite 'blended whiskey,' the back label, attached under the pressure of the Federal law, although in smaller print, admits that only a small percentage of the beverage can be classified as whisky while the rest is nothing but freshly distilled grain alcohol euphemistically called 'neutral spirits.' The same applies to the various cheaper brands of gin. These facts have frequently been stressed by Leary."

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[1] See "A Preliminary Paper Concerning the Toxic Effect of Certain Alcoholic Beverages for the Kidney of Normal and Naturally Nephropathic Dogs," by W. de B. MacNider. *Journal of Pharmacology and Experimental Therapeutics*, Vol. 26, pp. 97–104, September, 1925.

[2] See "Some Newer Aspects of the Alcohol Problem," by Timothy Leary. *New England Journal of Medicine*, Vol. 218, pp. 827–33, May 19, 1938.

[3] See "Alcoholism and Mental Disease," by Leo Alexander, in *Mental Health*, edited by F. R. Moulton and P. G. Komora. (Publication No. 9 of the American Association for the Advancement of Science.) Lancaster, Pa.: The Science Press, 1939. pp. 83–90.

We wish to emphasize at this point what we have stressed in other writings—namely, that we are not prohibitionists, and in fact, regard prohibition as a failure and obstructive to the goal of real temperance. We believe that the drinking of alcoholic beverages is firmly established in the natural customs of mankind, because it fulfills certain useful purposes—it facilitates social relationships, it dulls the edge of adversity, and it acts as an instrument for ceremony and social dignity. We stand strongly for the temperate use of alcoholic beverages. We believe in and recommend moderation. Properly used—and that means properly sold and advertised under the provisions of the Federal Food, Drug and Cosmetic Act, with appropriate directions for use and with honest warning labels—alcoholic beverages of good quality would certainly do less harm and, on the contrary, would probably be of more social value.

In our opinion, the realistic enforcement of this act would be a most important force for the gradual education of the public to temperance. If properly applied, it would compel the liquor industry to carry on propaganda for temperance on their own liquor bottles. Though a warning label would certainly not deter a confirmed alcoholic in the late stages of addiction, it would undoubtedly do a great deal for the prevention of alcoholism. For any one who reads such a label, and who has not yet become an alcohol addict, would be aided to realize that he is ingesting a powerful substance which can readily get him into trouble physiologically, psychologically, and socially.

Many authors have agreed that the attitude of the community toward excessive drinking is the main determining factor working for or against the production of excessive alcoholism in the community.[1] A sensible warning label will probably exert a wholesome influence upon the attitude of the community. At present only those who want to be enlightened can be reached by any educational program, and we can think of no better vehicle for carrying education to those who need it most than the label of the liquor bottle itself. The warning label should be sensible and sane—that

[1] See "Alcohol: A Study of Social Ambivalence," by Abraham Myerson. *Quarterly Journal of Studies on Alcohol*, Vol. 1, pp. 13–20, June, 1940.

is, free from exaggeration and yet explicit in its statements. Our idea of a label is somewhat as follows:

> *DIRECTIONS FOR USE: Use moderately and not on successive days. Eat well while drinking and, if necessary, supplement food by vitamin tablets while drinking. WARNING: May be habit-forming; not for use by children. If this beverage is indulged in consistently and immoderately it may cause intoxication (drunkenness), later neuralgia and paralysis (neuritis) and serious mental derangement, such as delirium tremens and other curable and incurable mental diseases, as well as kidney and liver damage.*

There are many people who are afraid to take two aspirins at a time for a cold, because of its possible effect on the heart. But these same people do not hesitate at all to take six highballs in a row. We think that this inconsistency in public opinion and knowledge should be corrected.

Physicians to-day fully realize that alcoholism is the greatest single public-health drug problem. Physicians strongly support the Federal Food and Drug Administration in its general operations and in its special task of protecting public health from intoxication and from mental derangement following or associated with the use of any drug. Physicians are further aware that the Federal Food, Drug and Cosmetic Act is primarily designed to promote public welfare and not to protect a special group of manufacturers or industrialists. It would appear that in the present-day operation of the law the greatest single drug problem in the United States is neglected. The overlapping of authority has resulted, not in protecting the American public by virtue of excessive legislation, but rather in defeating the primary purpose of the public policy behind both these laws—that is, the protection of public health. This is a state of affairs in which physicians are not only vitally interested, but against which they should firmly and uncompromisingly act.

It is our opinion that if the Federal Food, Drug and Cosmetic Act does not apply to the distribution and sale of alcoholic beverages, it most certainly should.

ATTITUDES OF PRIMIPARÆ AS OBSERVED IN A PRENATAL CLINIC

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AS an introduction, I want to quote a paragraph from a report made in 1930.[1] It is as follows:

"I wish to mention an idea concerning a possible future trend in mental hygiene. At present, child-guidance work, dealing with problem children ranging, in general, from five to fifteen years of age, is the outstanding mental-hygiene activity. However, for some time it has been recognized that the very early years are the important ones in all mental-hygiene problems, and also the philosophy of child-guidance work has shifted from the treatment of symptomatic behavior to study and treatment of underlying factors with special emphasis on the parent-child relationship. Therefore, it is suggested that as one important and practical starting point for mental hygiene, dealing with both parent and child problems, we should start educational work with parents in the prenatal period along with the instruction usually given in physical hygiene. The guidance should then be continued through what might be termed well-baby mental-hygiene clinics, following a lead taken long ago in physical hygiene. Such guidance should be based on positive constructive factors as well as on our knowledge of the negative destructive factors. Ways and means of carrying out such a program, and sufficient knowledge on the subject, seem to be at hand to warrant a practical start of such a project. No one has contributed more to this fundamental knowledge than one of our own board members, Dr. Arnold Gesell."

Rewriting such a paragraph to-day would call for some different choice of words and more recognition of what is being done for the pre-school child, but the general idea would

[1] The Twenty-second Annual Report of the Medical Director of the Connecticut Society for Mental Hygiene. *Mental Hygiene News*, June, 1930.

be the same. It is the purpose of this paper to elaborate that idea further.

We are aware of what the public-health movement has accomplished in this century by concentrating on the prenatal period and the first years of life. The decline in maternal and infant mortality and morbidity rates is striking evidence of what has been done. However, in this consideration of "public health" from the standpoint of mental hygiene, our thoughts are not primarily directed toward the prevention of psychoses in parents or children. Essentially, our considerations have to do with the emotional atmosphere into which the child is to be born and with the question how the child can be given more intelligent care and training, especially during the first two years of life. That this emotional atmosphere and intellectual approach depend upon the innate personalities, the interpersonal relationships, and the cultural, even the economic, status of the parents, as well as upon the parent-child relationship, does not call for further elaboration to-day. However, physicians have been so accustomed to think of the new-born child as needing only fresh air, sunshine, proper food, and adequate rest that seldom do they consider that an atmosphere of security, serenity, and lack of tension may be just as important.

Before the date of the above quoted report, this topic was discussed with the psychiatric social worker of the New Haven Visiting Nurse Association and various possibilities for practical applications of the idea were studied from time to time. Later, the prenatal classes of the visiting nurses were attended and, although it was found that considerable emphasis was being placed upon mental health, assistance was given toward bringing about more discussion of mental-health topics in these classes. Also there was participation by the psychiatrist in councils held for "expectant fathers."

It was evident, though, that parent education, as exemplified by the efforts of the Child Study Association of America, the Parent-Teacher Associations, and the Visiting Nurse Association, was not enough. Child training or guidance, like all other interpersonal relationships, is only secondarily a matter of knowledge and rational choice. Fundamental are

the often unrecognized emotional conflicts of the parent-child and the parent-parent relationships. Therefore, it was thought that it would be desirable for a psychiatrist to attend the prenatal clinics, to interview the prospective mothers and approach the situation from a fact-finding point of view. Naturally such an approach could not eliminate the therapeutic challenge and the bringing to it of certain conceptions mentioned above.

Attendance of the psychiatrist in the prenatal clinic of New Haven Hospital began October 11, 1938. These clinics are held three mornings in each week. Except for the multiparæ who presented special problems, the interviews were limited to primiparæ, and approximately two-thirds of these women who came for the first time with their first pregnancies were seen by the psychiatrist. The only element of selection was in connection with the unmarried-mother group, because they automatically became social-service clients and it is part of the general work of the psychiatrist to deal with these clients.

As had been suspected, it was evident from the beginning that these women wanted help—wanted to talk with a physician about any and all problems and desired not only advice, but understanding for and of themselves. Without appearing critical, we must recognize that in a busy clinic there is little chance for the prospective mother to talk with the obstetrician about her attitudes, her problems, and her misconceptions. In the psychiatric interview, this became possible and many women spoke about the opportunity they had had to discuss stored-up questions or fears which they had wanted to bring to a "doctor." In only three instances was there any evidence of resistance or of reluctance to talk about rather personal topics.

An attempt has been made to reduce some of the findings to a numerical basis, using the first one hundred cases without selection.[1] Except for a few of the general figures, it must be admitted that many may not be absolutely accurate because they depend on the conscious or unconscious truthfulness of the patient as well as the interpretation of the psychiatrist.

[1] Study of the psychiatrist's notes, as well as social-service, medical, and nursing records by a psychiatric social worker, has helped to round out these observations.

Many of the patients were seen more than once, some having five or six interviews, and a few were seen in the hospital after delivery or were followed through social agencies after discharge from the hospital.

In a dispensary, of course, we are dealing with a selected group, particularly from the standpoint of economic status. Only eight of the one hundred cases could be considered to be living under modestly comfortable circumstances, while the status of forty-two was marginal. To the latter should be added fourteen cases in which the husband was employed by W.P.A. Sixteen of the hundred were entirely dependent upon relatives, and here we find several of the unmarried women. Twenty were completely dependent on relief, but in only three instances was the relief coming from a private agency. This seems significant in view of the fact that private social case-work agencies should be interested in "young families." At the time of the first interview, twenty-seven husbands were unemployed, and in thirty-five cases the husband had been unemployed at some time during the pregnancy. In many instances the husband became unemployed soon after the wife conceived.

In New Haven, where the proportion of the foreign-born population is comparatively large, factors such as cultural and religious background are important. There were sixty Catholic women in the group and the Catholic husbands numbered fifty-six, but in only fifty-one instances were both partners Catholic. Three of the Catholic women were unmarried, and in fourteen marriages in which one or both of the couple were Catholic, the marriage had not been recognized by the Church.

In only twenty-two marriages were both partners from what could be called American stock. In twenty-three marriages the partners were Italians, while in twenty-one instances there was a mixture of nationalities. Eight of the married women were Negroes; five of this number had made forced marriages, and among the unmarried women five were colored. It is interesting that there was only one Jewish couple.

In such a clinic the question of intellectual level arises, but

although no routine psychological examinations were done, it is our impression that the majority of the women were of a level of intelligence approximating what is considered average. A general impression, based on family history, school attainment, work record, and the individual interview, led us to a classification of seventy women as average, thirteen as below average, and fourteen as above average in intelligence. Three were definitely feebleminded, as shown by former psychological examination.

A tabulation of the data on the marital status of these women gave the following results:

Marital status	*Number of cases*
Legitimate marriage	68
Forced marriage	15
Unmarried	14
Doubtful	3
	100

According to these figures, almost one-third of the conceptions came before there was a legitimate marriage, but among the sixty-eight so-called legitimate marriages were the fourteen Catholic women whose marriages had not been recognized by the Catholic Church. This brings the proportion of pregnancies in which grave reservations must have existed to exactly 46 per cent. An exception to this might be found in the case of a colored woman who reported that she became pregnant in order to bring about her marriage to a procrastinating suitor.

It should be mentioned again that practically all the unmarried mothers were seen and that, therefore, the proportion of the unmarried to the total enrollment of the clinic is not quite so great as the table indicates. One of this group married after the child was born and the husband refused to live with her. One other woman married just before delivery.

The doubtful marriages were so classed because the women expressed doubt as to the validity of the marriage ceremony or because no records of the marriages could be found. One woman said that she was married in June, 1938, that she became pregnant the following month, and that the marriage

was annulled by her mother-in-law on the basis of fictitious ages in August, 1938. All the evidence so far available indicates that there was no marriage ceremony. Another woman felt fairly certain that her supposed husband had persuaded a friend to pose as a minister, because she had not been able to obtain a copy of the marriage certificate.

In the total group there were thirteen colored women, of whom three had been legitimately married before conception, five had been married after conception, and five were unmarried.

With regard to attitude toward the partner, the findings were as follows:

	Number of cases		
Attitude toward partner	Total	"Forced" marriage	Doubtful marriage
Congenial	62	11	0
Friction	12	3	0
Separated	11	1	3
Husband dead	1	0	0
Unmarried	14	–	–
	100	15	3

This tabulation indicates that not quite two-thirds of the couples were "happily married." In all probability there were in the so-called "congenial" group a few who hesitated to disclose marital friction, so the proportion of the happily married may not be so large as our figures would indicate. It should, however, be mentioned that in three of the separated cases the couples were on good terms and the separation had been the result of illness or of financial difficulties. It is interesting that so many of the forced marriages were reported as "congenial." This, again, may have been a defense in a few cases. The fact that in one out of every four pregnancies no father would be present at the birth of the baby appears especially significant.

These data as well as the others call for the reminder that the attitudes expressed are almost entirely those of the women. Unfortunately, in only a few instances was it possible to interview the husband.

The tabulation below gives the data on sexual adjustment in relation to marital status:

Sexual adjustment	*Number of cases*			
	Total	Unmarried	"Forced" marriage	Doubtful marriage
Satisfactory	39	3	10	0
Partially satisfactory	23	3	3	0
Frigidity	23	5	2	0
Questionable or unknown	15	3	0	3
Total	100	14	15	3

In all probability a few patients reported satisfactory sexual relations without knowing what was meant or because of reluctance to admit failure. It appears safe to assume, however, that in about one-third of the group sexual adjustment was satisfactory. Here, too, we do not have the attitudes of the husbands, but in a few cases we do have frank admission that the husband was being deliberately deceived. Among the "partially satisfactory" were those cases in which orgasms were experienced only occasionally or in which there had been some change in response during the marriage. The latter included several instances of the disappearance of sexual desire with the onset of pregnancy because of fear of consequences, but there were a few cases in which response came only after the pregnancy had started, possibly as a result of the release from fear of pregnancy. Only those who admitted without reservation that there was complete frigidity were so classified. Probably there were others. Where there was hesitation or evidence of evasion in discussing the subject, the classification of "questionable" or "unknown" was used. The fact that ten out of fifteen of the forced marriages claimed satisfactory sexual relations appears significant.

Some of the reasons for sexual maladjustment in approximately two-thirds of the women were more or less obvious, but many of the deeper-lying causes could not be brought out in such interviews. Cultural and sometimes religious attitudes instilled in early life seemed to be very important. Among the unmarried or those forced into marriage, the associated guilt was a strong factor, but that this was not always true is indicated in the table. Evidence of overt or latent homosexuality, either through direct admission or

from observation of behavior, attitude, or history, was strikingly absent in the majority of the group.

The data on attitude toward pregnancy are shown below in connection with marital status:

Attitude toward pregnancy	*Number of cases*			
	Total	Unmarried	"Forced" marriage	Doubtful marriage
Planned pregnancy	17	0	0	0
Unplanned pregnancy:				
Still unaccepted	16	5	1	1
Partially accepted	45	8	11	2
Fully accepted	18	1	3	0
	79	14	15	3
Unknown or questionable	2	0	0	0
Planned, but later rejected	2	0	0	0
	100	14	15	3

The acceptance or rejection of a pregnancy is in all probability never 100 per cent either way, especially in view of the fact that more than one person is concerned. This table must, therefore, be interpreted as a very relative expression of attitudes. The drawing of lines was difficult and the interpretation of the psychiatrist depended upon much more than the subjective statements of the prospective mother. Efforts were made to include as far as possible the attitudes of the prospective fathers. The interpretation of attitude depended not only on the woman's expressed view, but upon other concrete evidence, such as postponement of the clinic visit, postponement of confirmation of pregnancy, actual or contemplated attempts at abortion, attendance at mothers' classes, planning for a layette, interest in child care, and so on. The change in attitude was almost entirely toward acceptance, even in the group of unmarried mothers.

The occurrence of unplanned pregnancies in over three-fourths of these cases is important when we consider that these people were for the most part unprepared financially or otherwise for the conception. The later acceptance must have remained a relative matter which would continue to influence attitudes long after the child was born. Thirteen women admitted definite attempts to produce an abortion and four others would have done so had they not been prevented by others or by their own ignorance, but in all

probability there were more who hesitated to disclose such procedures, either actual or desired.

The data on the use of contraceptive measures more or less speak for themselves:

Contraceptive measure	*Number of cases*
No contraceptive measures	63
Coitus interruptus	10
Condoms	8
Douche	5
Suppository	3
Combination of above measures	8
Pessary	0
Unknown	3
Total	100

Religious attitudes did not play as large a part here as might have been expected. In the majority of illegitimate pregnancies and "forced" marriages, no contraceptive measures were used and in the remaining few only the "unsafe" measures were adopted. Under these circumstances fear of pregnancy was very common and must have played an important rôle in some of the inadequate sexual adjustments.

A correlation of age at time of conception with marital status resulted as follows:

Age at time of conception	*Number of cases*				
	Total	Legitimate marriage	"Forced" marriage	Doubtful marriage	Unmarried
14	2	–	1	–	1
15	2	–	1	–	1
16	4	–	2	–	2
17	6	3	–	–	3
18	7	4	2	–	1
19	13	4	4	2	3
20	5	5	–	–	–
21–25	44	36	5	1	2
26–30	12	12	–	–	–
31–35	2	2	–	–	–
36–40	3	2	–	–	1
Total	100	68	15	3	14

One significant point in this classification appears to be that out of thirty-four women whose pregnancies occurred under twenty years of age, only eleven were legitimately married before conception. In two-thirds of the forced

marriages conception occurred in women below the age of twenty. On the other hand, in approximately five-sixths of the legitimate marriages, conception occurred in women who were twenty years of age or over.

Additional data on these cases could be tabulated and will be in the future, but consideration of individual patients from various aspects gives a different and perhaps a clearer picture. A general, but very abbreviated summary of the first ten of the one hundred cases, arranged alphabetically, illustrates some of the problems presented:

1. B. A. A twenty-six-year-old woman, married four years. Her husband lost his job for the first time just after she became pregnant. She was ashamed to go out from her home because of modesty. She was ashamed also to tell doctors of her worries.

2. H. A. A very doubtful marriage, probably an affair between a waitress and the son of a wealthy family. The parents of the couple were not informed about the marriage and the pregnancy even after the baby was born. The patient's mother was in a state hospital for mental diseases. One year later the patient was back at work supporting her baby, but the husband had disappeared.

3. P. A. A French woman who has been in this country a short time. She had no relatives and few friends and could not speak English. One year later, she appeared with her second pregnancy.

4. D. B. An eighteen-year-old colored girl, illegitimately pregnant. She, herself, is the illegitimate daughter of a woman who has been in a North Carolina State Hospital for several years. The patient developed a postpartum psychosis, and her aunt, with whom the baby was left, also became psychotic and was committed.

5. C. B. A nineteen-year-old girl who said that she had been married in California in June, 1938. Her last menstrual period had been in July of that year, and the marriage had been annulled by her mother-in-law in August, because the husband was only seventeen years old. Efforts to confirm these statements were unsuccessful. The patient had returned to relatives in New Haven, but was destitute and without adequate diet. A year later she was working, the baby was in a foster home, and the husband was still missing.

6. A. B. A twenty-one-year-old woman who dreaded coming to the clinic because she was so modest. Conception had occurred about one month after marriage, but the pregnancy was accepted.

7. L. B. The pregnancy was planned, but the husband contracted gonorrhea from a prostitute and the couple feared that the baby would be blind or an idiot.

8. A. C. An eighteen-year-old Italian girl who married a Pole two months after conception. With the aid of her husband, she had attempted abortion. Sexual satisfaction was only occasionally attained because of her husband's inability to wait for her.

9. D. C. A twenty-two-year-old girl, formerly an inmate of a county home. The patient's I.Q. was 66 and she came from a family of subnormal children, but she appeared to be making a good marital adjustment.

10. E. C. A thirty-one-year-old colored woman, above average in intelligence, probably very much attached to her father. No sexual response since the onset of pregnancy. Marginal financial status.

Other individual cases could be summarized to illustrate such points as fears, superstitions, misbeliefs, feelings of guilt, reasons for postponing the first clinic visit, reasons for rejecting the pregnancy, causes of marital friction, and factors in poor sexual adjustment. However, a more complete presentation of two cases will illustrate many of these points and show their interrelations.

These cases are presented just as they were recorded after the initial interview. They illustrate the amount of material that may come to light at the time of the first clinic visit.

Case 1.—D. W. "This twenty-year-old woman was seen at the time of her first visit in the prenatal clinic and before she had had the routine physical examination. In the waiting room it was noted that she did not look very happy and she immediately corroborated this by saying, 'I don't care one way or the other. If the baby comes, it's all right. If it doesn't, I won't care because I have no home for the baby.'

"The patient's father died when the patient was six years of age. She doesn't remember much about him, but says that she has never had a father person in her life. The father was English and the mother is from Hungarian stock and both parents come from Catholic families. There is only one sibling, a nineteen-year-old brother, who is employed at $55 a month and who contributes almost all of this to the mother, with whom he lives. This brother has a chronic skin trouble which is obnoxious to the patient. The patient's mother is a dressmaker and has supported the family since the father's death. The patient describes her as a dominating, nagging, and nervous person.

"The patient attended Commercial High School for three years and then quit in order to go to work. She was steadily employed in fur shops during the season, and at other times she helped her mother at dressmaking, but received no pay for this and had to ask for spending money.

"The patient says that she married in order to get away from her mother and the home. She was secretly married in New York by a justice of the peace and returned to her home that night, so that she was not missed. There were no sex relations at that time. When news of the marriage was broken to the mother, there was great opposition, but also insistence on a church wedding, which took place in August, 1937.

"The patient's husband is twenty-three years of age. He is an Italian Catholic and, as the patient says, 'He is thick and stubborn like the

rest of them.' He has been employed on a W.P.A. laboring job since marriage. He comes from a family of six siblings, and it is a very mixed-up family. Some of his siblings are married, separated, and divorced. One divorced daughter-in-law is living in his home. The patient describes the husband's family as one in which there is constant tension and fighting and where nobody is happy. With regard to the husband, the patient says he is nervous and his mother spoiled him. He never had to do anything for himself. After marriage she found him very helpless and he wouldn't do much to help her. He just wanted his own way and his own comfort and pleasure.

"After the church wedding, the couple started housekeeping in some furnished rooms, but the husband's brother and his new wife came to live with them and this led to considerable fighting and quarreling and the patient walked out. It is difficult to follow the sequence of events, but apparently she went back to her mother and later the couple tried living with his family, but this lasted a very short time. Finally they rented an apartment and bought some new furniture. After the patient became pregnant, the friction with her husband grew, and about two or three months ago she went back to live with her mother, while the husband took up residence in a nearby hotel because his own home was too crowded. The patient considered divorce at the time of this separation, but after a little more of her life with her mother, she gave this up and thought that life with her husband couldn't be any worse, and besides he recently has said that he missed her. But still they have not gone back together, although the rooms and the furniture are waiting for them. The patient states that she is afraid to go back to her husband because of what her mother might do. She says, 'She might even throw a meat knife at me.' As it is now, the patient's mother won't allow the husband in the home, so the patient goes down to the corner every night and talks to her husband.

"The patient states that she could never see anything in sex relations and she doesn't know what it is to get a thrill out of them. Even kissing does not stir any physical desire. Pregnancy has made no difference in this. Condoms were used for contraception, and the patient claims that she had no feeling of guilt about this. When asked if the pregnancy was definitely planned, she stated, 'Why, yes, I believe so. I think we stopped using condoms, but I can't remember exactly.' The patient states that when she was living with her husband, he would work all day, have little to say to her in the evening, and upon retiring he would get his sex satisfaction without saying much or paying much attention to her, and then turn over and go to sleep. She says that about all that she recognizes in regard to sex is what she calls a 'mother instinct.'

"The patient is very unhappy in her present situation, saying that she never has a chance to relax and sometimes has to help her mother until 3:00 A.M. on rush orders. The possibility of social-service assistance in this case will be considered."

Case 2.—F. Y. "The patient is a short-statured, somewhat obese twenty-eight-year-old Italian woman. This is her first visit to the clinic, and she reports that her husband had to force her to come. She has been pregnant almost six months. She never went to doctors

before and, besides, she says that she is very modest. She does not know what to expect in the examination nor in the birth of the baby. While waiting in the clinic, she heard some one cry during the examination, and she is afraid that she will be hurt.

"The patient comes from a family of eight siblings. She is the next to the oldest girl, and she says that she was very protected by her parents and she knew very little about sex and marriage, except what she read in a medical book. She has four younger siblings and during adolescence she had to help care for them as well as for small nephews and nieces. She states that she is 'fed up' with caring for children, doesn't like them, and doesn't want this baby, but guesses that she will have to take it.

"The patient graduated from Commercial High School at the age of twenty and went to work immediately as a secretary in order to get away from home duties. She has held fairly good positions, such as secretary to a doctor and other secretarial positions. Recently she was clerking in a store, but, she gave this up two weeks ago because her feet and ankles became swollen.

"The husband, aged forty-two, had been married before, but had no children. His first wife disappeared twelve years ago, and later he divorced her, but because of this the patient could not be married in a Catholic church. They were married by a justice of the peace and the patient states that she worries about this all the time. She has thought that she might lie to the church and get married by a priest, but the lie would be on her conscience and she would have to confess it. Her exact status with the church was not ascertained, but it is evident that in her own mind she is practicing adultery and the child is not a legitimate one, according to the church laws.

"The patient says that she was unprepared for her first menstrual period and was frightened at the time. She had been going with her husband for five years steadily before marriage. There was great opposition to the marriage by her family because the husband was a divorced man, but her parents knew that the wedding was to take place. After marriage the patient depended on douches alone to prevent pregnancy and claimed that she 'got by' for six months before 'being caught.' There is a possibility that this may have been a 'forced' marriage, because the patient was very indefinite about the time she had been married. The pregnancy was definitely unwanted and remains so. The patient took ergot and other medicines and thought of going for an abortion, but her husband would not let her. She states that she has not had any pleasure in sex relations, adding, 'How could I when I was so afraid of becoming pregnant?' Since the pregnancy, intercourse has been painful and, therefore, there has been no enjoyment.

"The husband has been a salesman, making a fair income, but six weeks ago he lost this position and the couple are now dependent on the department of charities. The patient hates this, but says that her husband has prospects of another job in the near future. Because she is so modest she will hardly go on the street in the daytime. She knows very little about the birth of a baby except that she has 'heard women yell at such times.'

"She agrees to see the psychiatrist when she comes to the clinic again."

Thus far it has not been possible to carry out a detailed personality study of each expectant mother, and, as indicated above, we know very little about the expectant fathers. The findings are limited almost entirely to economic, social, and cultural factors and to the consciously expressed attitudes of the pregnant woman. Perhaps more important and enlightening would be an understanding of the personalities of both parents from the standpoint, not only of original endowment, but of life experiences and degree of emotional maturity. An emotionally mature woman is one who has passed successfully and on time through the various stages of emotional development from complete dependence to a greater or less state of independence, with ability for self-guidance and ability to make an adult heterosexual adjustment. This implies satisfaction in the early relationship to her own mother, a real love for her father, and an ability to identify with her mother, who in turn really loves the father. In many instances such a woman may be able to meet well the challenge of child-bearing and child-rearing, regardless of social and economic handicaps. That an equal degree of emotional maturity in the father is desirable is a point that should not be overlooked.

Granting the incompleteness of our study, we feel that within the limitations of the positive findings, there are in almost every family of this clinic sampling many problems that are not conducive to a good marital adjustment and to the birth of a healthy, wanted child. These problems often become acute during pregnancy, and they are practical problems which our patients want to bring to a doctor or a nurse, who frequently can give valuable assistance if they will listen to the patient's story. This does not mean that every pregnant woman should be under the care of a psychiatrist, but it does mean that all doctors and nurses who have anything to do with obstetrics should give due attention to the adjustment of the total individual and not focus all attention on the lower half of the torso. Practically, it seems highly desirable that every obstetrical clinic should have at least one full-time psychiatric social worker and that this social worker, as well as the obstetricians and nurses, should have the advisory and consultative services of a psychiatrist.

PLACING THE CHILD FOR ADOPTION

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EVERY social worker recognizes the importance of security for the dependent child, but many social workers retreat from the finality of adoption, which experience shows is full both of gross and of subtle hazards. Yet it is generally agreed that it is the permanence and the finality of legal adoption that make possible the security and sense of belonging that should be associated with child placement. There is risk in adopting a child and there is risk in being adopted. None the less, since adoption is the procedure that, in the light of our present knowledge,[1] offers the greatest protection to the dependent child, our entire effort should be directed toward expanding our adoption program and improving the efficiency of our adoption technique.

We can no more eliminate the hazards of adoption than we can eliminate the hazards of marriage, but we can struggle ceaselessly to minimize them. We do not yet know enough to be able to lay down didactic laws about adoption placements, but we can all study, by direct observation, the effects of placement on children and on adopting parents. We can also scrutinize and evaluate what research workers in the fields of psychology, genetics, medicine, sociology, and education have to say that may be applied to our immediate problems. The worker who limits her interests either to direct clinical work or to theoretical, academic concepts cripples herself and her clients.

The adoption worker's chief concern is how to find the right home for the right child with such efficiency that the child is placed early and permanently and the adoptive parents are satisfied that he will be in truth one of them and not a stranger among them. The social worker must be courageously aware that the placement she makes will deter-

[1] See *Social Aspects of Adoption*, by Sophie Van S. Theis. New York: Child Welfare League of America, 1937.

mine the future course of the life of the child and the future happiness of the family. Her adoption placements must, therefore, be made thoughtfully, but promptly, after an evaluation of the child and of the adoptive home.

I.

In the evaluation of children for adoption, the social worker is faced with two distinctly different problems. The first is the evaluation of the socially inaccessible, newborn infant, not yet influenced by experiences or emotional relationships. The second is the evaluation of the older child whose performance can be observed and who can perhaps give some account of himself, but whose personality is complicated by the inclusion in it of elements of the personalities with whom he has grown up, as well as by reactions to the experiences through which he has lived. The private physician or the nonprofessional agency usually concerns itself only with the adoption of infants, but the social worker is faced with dependent children in both age groups. She can, and she often does, hope to simplify her problem by allowing the infant to grow up in a "controlled environment" to an age of greater accessibility. Though the child can now be talked to and tested, he is by no means a more "sure bet" for adoption; in fact, new hazards have been introduced.

If the adoption of a newborn infant is contemplated, the study of him is perforce limited to a study of his heredity and to medical examinations. Of the two, the latter is far the more convincing and satisfying. A good pediatrician, with adequate laboratory facilities, within the first few weeks after a child's birth can state whether there are any gross abnormalities of structure or congenital disease processes. Certainly no baby should be placed for adoption who has not been examined by a competent physician—or, better, by a pediatrician—and this examination should include laboratory studies. Thoroughgoing physical and laboratory examinations, combined with an adequate medical family history (usually absent from social records), should rule out from blind adoption placement a group of grossly handicapped children. This group includes children suffering from hereditary degenerative disease of the nervous system,

Friedreich's ataxia, congenital blindness and deafness, Huntington's chorea, congenital syphilis, and hemophilia.[1] Concerning the unsuitability for adoption of this group of children, except under peculiar circumstances, there has been little controversy.

Most of the babies for whom social workers must plan do not represent any such definitely pathological familial history, and most of them pass muster by the pediatricians as healthy specimens, free from congenital disease. But many of these babies have factors in their family histories that, in the present state of our knowledge, cannot be evaluated. These factors some regard as definite deterrents to adoption, others disregard them, and still others are on the fence about them.[2] These include (1) psychosis that cannot be explained on an organic basis (manic-depressive psychosis and schizophrenia); (2) familial feeblemindedness; (3) epilepsy; (4) alcohol and drug addiction; (5) criminality; and (6) general emotional instability.

Family histories weighted with these conditions do give one cause to consider carefully the steps to be taken. There is as yet no definite knowledge as to how great a rôle heredity plays in any of these conditions. Theis emphasizes that "laws of heredity are complicated, and care must be taken not to let a little knowledge of this point play too powerful a part."[2] Indications, still far from final, are that psychosis, as defined above, some types of feeblemindedness, and perhaps epilepsy[3] may have significant hereditary factors. Whether these factors operate to an important extent entirely apart from the environmental situations that, in the natural family, are their concomitants, we do not know. The import-

[1] On this point see the following: "Suitability of Children for Adoption," by Hyman Lippman (*American Journal of Orthopsychiatry*, Vol. 7, pp. 270–73, April, 1937); "Adoption Practices and the Physician," by R. L. Jenkins (*Journal of the American Medical Association*, Vol. 103, pp. 403–8, August 11, 1937; also published as a reprint by the Child Welfare League of America); and *Eugenical Sterilization*. (Report of the Committee for the Investigation of Eugenical Sterilization, the American Neurological Association. New York: The Macmillan Company, 1936.)

[2] See Theis, *op. cit.*

[3] See "The Inheritance of Epilepsy as Revealed by the Electroencephalograph," by W. G. Lennox, E. L. Gibbs, and F. A. Gibbs. *Journal of the American Medical Association*, Vol. 113, pp. 1002–3, September 9, 1939.

ance of identifications or extreme reaction formations in the children of psychotic, feebleminded, and epileptic parents cannot be overlooked. Alcohol and drug addiction, criminality, and emotional instability have even less definite evidence to support them as absolute contraindications to adoption.

More studies are needed patterned after that reported in Theis's *How Foster Children Turn Out.*[1] Among the 910 children studied, covering the period from 1898 to 1922, 269 were adopted. Of these 269 children, 145 were foundlings and 45 more came from families about whom very little was known. Among the 235 adopted children who were followed up, 207 were found to be making an adequate adjustment. "More than two-thirds of those children who had what seemed to be a most unpromising of all possible starts are rated as capable" (making an adequate adjustment). Theis's study indicates that children placed early in life tend to adjust more successfully than those placed after the age of five.

In this early study, details as to true family background are, for the most part, lacking. Extensive follow-up studies of adoptions of infants of known heredity who were placed fifteen or twenty years ago would make valuable contributions to our knowledge as to the adoptability of children whose true family histories are generally regarded as unfavorable. Workers in adoption would do well to apply to their field the careful evaluation of past work that is to be found in the field of delinquency in the Gluecks' *"One Thousand Juvenile Delinquents,"*[2] or in the field of child welfare in *The Rehabilitation of Children,* by Baylor and Monachesi.[3]

The adoption of the newborn infant is a ticklish business, but, when skillfully and thoughtfully carried out, it probably offers a better prognosis than does the adoption of an older child. Social workers should question carefully, but not arbitrarily rule out, the possibility of adoption of infants whose hereditary history is weighted with psychosis, feebleminded-ness, epilepsy, addiction, criminality, or general emotional

[1] New York: State Charities Aid Association, 1927.
[2] Boston: Harvard University Press, 1934.
[3] New York: Harper Brothers, 1939.

instability. When these conditions occur in the family history, nothing is to be gained by waiting until the child is two or three years old before deciding whether or not he is eligible for adoption. Of these conditions, only feebleminded-ness would definitely and surely show itself within the age period when the child would still be likely to be adoptable, and the disadvantages of institutional care or replacement outweigh the advantages gained by postponing the decision as to adoptability. A one-, two-, or three-year probationary period would protect parents from assuming responsibility for a feebleminded child or a child whose epilepsy or emotional deviation was grossly apparent early in life. The social agency's aim for every newborn dependent child should be for the earliest possible permanent placement, either with relatives or in an adoptive or permanent boarding home.

The dependent child of pre-school age may be the agency's first client, rather than the unmarried mother who seeks for a plan for her unborn baby. These children of one to five years are not infrequently the illegitimate babies whose mothers retained custody of them, either at the mother's own insistence or in response to maternity-home or other external pressure. These children not only are dependent, but also have been neglected physically or emotionally. They have suffered rejection and usually replacements. Their social, intellectual, and emotional development has been either inhibited or warped. Personality reaction patterns or ego defenses have already been established, but fortunately are not yet rigid and fixed.

This more finished product, on the surface, appears to be easier to evaluate than the newborn, wrapped in the cocoon of infancy. Medical examination of a pre-school child, however, reveals relatively little more than medical examination of an infant, except as regards physical appearance and structure. The family history is about equally important for the two age groups.

The pre-school child can be subjected to a battery of tests and can be given an I.Q. rating, but the meaning of that I.Q. is by no means obvious. During the past three years a series of startling papers have come from the Iowa Child Welfare Research Station concerning the tremendous changes in I.Q.

observed in children under certain environmental conditions.[1] These findings would seem to have been to some extent confirmed by those of a study conducted by the child-caring agencies of St. Paul, Minnesota.[2] Although the Iowa studies have been severely criticized,[3] workers in the field of adoption would do well to remember that the extent to which the I.Q. is capable of modification has not as yet been definitely determined.[4] There is evidence that the I.Q. does change and that it may represent an evaluation of the child's environment and experience rather than of his inherent possibilities. Many of us have dealt with cases in which a child's intellectual development proceeded normally through infancy and early childhood, and then, after some major traumatic experience, came to a standstill or was markedly slowed down.[5]

The I.Q. of the pre-school child has significance only as an expression of the child's present state of development, which has been conditioned not merely by constitutional factors, but also by his life experiences. Theis [6] asserts that workers

[1] See the following three papers by Beth Wellman: "Mental Growth from Pre-school to College" (*Journal of Experimental Education*, Vol. 6, pp. 127–38, December, 1937); "Our Changing Concept of Intelligence" (*Journal of Consulting Psychology*, Vol. 2, pp. 97–107, July-August, 1938); and "Guiding Mental Development" (*Childhood Education*, Vol. 15, pp. 108–12, November, 1938). See also "Mental Development of Children in Foster Homes," by Harold Skeels (*Journal of Consulting Psychology*, Vol. 2, pp. 33–43, March–April, 1938) and the two studies by Marie Skodak, "Mental Development of Adopted Children Whose True Mothers Are Feebleminded" (*Child Development*, Vol. 9, pp. 303–8, September, 1938) and *Children in Foster Homes* (Iowa City: University of Iowa, January, 1939).

[2] See "Effect of Foster-Home Placement on the Intelligence Rating of Children of Feebleminded Parents," by Jessie Wells and Grace Arthur. MENTAL HYGIENE, Vol. 23, pp. 277–85, April, 1939.

[3] See the two papers by Florence Goodenough, "Look to the Evidence!" (*Educational Methods*, Vol. 19, pp. 73–9, November, 1939) and "Can We Influence Mental Growth?" (*Educational Record Supplement*, Vol. 22, pp. 120–43, January, 1940).

[4] Florence Teagarden, in her recently published book, *Child Psychology for Professional Workers* (New York: Prentice-Hall, 1940) devotes considerable space in her second chapter to a review of the nature-vs.-nurture controversy. At the end of that chapter, she presents a bibliography on this important, but still unsettled, subject.

[5] See "Some Aspects of the Problem of Adoption," by Florence Clothier. *American Journal of Orthopsychiatry*, Vol. 9, pp. 598–615, July, 1939.

[6] See *Social Aspects of Adoption*, *op. cit.*

must have "imagination about the potentialities of children and their capacity to grow and develop and a conviction that change is inevitable. . . . Children can and do expand and grow, each in his own individual way, to an amazing degree under favorable circumstances."

Gesell,[1] in his defense of psychometric tests as valuable guides and protection in the field of adoption, says:

> "The infant, to be sure, is very immature, which tends to make him inscrutable; but, on the other hand, he matures at an extremely rapid rate, and this tide of maturation brings him more repeatedly and more cogently within the purview of systematic observation. . . . The rate and limits of his growth may also be foreshadowed by the manner and the fullness in which he makes the first stage of his developmental journey, say from 4 months to 12, or 18, or 24 months. . . . The reader, however, must not be left with any misconceptions concerning the automatic precision of the diagnostic procedures. They do not operate automatically at all; their final usefulness hinges upon trained clinical judgment. The normative developmental schedules furnish an objective basis for the construction of a considered estimate and for a comparative evaluation of successive examinations. In this sense they favor verifiable as opposed to intuitive appraisal. It must be remembered that all diagnosis deals with probabilities and not with absolute prophecy. It is here the aim to reduce the likelihood of error in such important situations as placing a child in a foster home."

The pre-school child is also subject to appraisal by the intuitive or psychiatrically trained observer. Theis[2] states that "in practical adoption work it is the child's own readiness to accept new relationships and his capacity for relating himself emotionally to his new parents that determine his placeability more than any one other factor." And Jenkins[3] says: "The behavior of the child should be noted with an eye to estimating his aggressiveness or timidity, sociability or seclusiveness, adaptability, emotional stability, response to various measures of control and other characteristics that may be of importance in determining his adjustment in a home."

The worker who is responsible for recommending for adoption a child of pre-school age or older must take into account not only the poorly understood influences of heredity and

[1] See "Psych-clinical Guidance in Child Adoption," by Arnold Gesell, in *Foster Home Care for Dependent Children* (U. S. Children's Bureau Publication No. 136, revised edition). Washington: Government Printing Office, 1926.

[2] See *Social Aspects of Adoption, op. cit.*

[3] *Op. cit.*

constitution, but also the subtle influences of environment and experience, so difficult to determine. These two forces exist in the presenting personality or ego of the child as compromises, conflicts, or contradictions. The child's physical well-being, as well as his mental status, is deeply modified by them. Constitution offers broad limits as to physical and intellectual endowment, but achievement in either sphere of life depends on other factors than heredity alone. It is not unlikely that the favorable intellectual response to environmental stimulus reported in the Iowa studies is to be explained by the child's identification of himself with new love objects in his expanded horizon.

In general, it seems to be true that the child whose psychosexual development has been frequently interrupted by changes of environment that have limited his capacity for identification with love objects is unlikely to be able to form the emotional relationships necessary for healthy social development.[1] These children do not easily make the transition from an orientation toward their aggressive demands to an orientation toward tender, loving impulses. They remain restless, impulsive, demanding, and unsatisfied. They cling to infantile sources of gratification instead of reaching out for the responsibilities of maturity.

II.

No less difficult than the evaluation of the child is the evaluation of the prospective adoptive parents. Theis[2] points out that "after suitability as to usual standards of good character and living conditions have been established, there will be subtler elements for consideration. . . . Subjective, as well as objective, factors in the home must be understood. . . . The crux of good adoption work probably lies in the adoption worker's ability to give wise and imaginative assistance in the selection of the right home for the child who can accept placement."

[1] See "The Problem of Frequent Replacement of the Young Dependent Child," by Florence Clothier (MENTAL HYGIENE, Vol. 21, pp. 549–58, October, 1937) and "Social Development of the Young Child," also by Florence Clothier (*Child Development*, Vol. 9, pp. 285–97, September, 1938).

[2] See *Social Aspects of Adoption, op cit.*

The prospective adoptive parent comes to a social agency as a client in need of help. Whatever his motive may be, he is taking what is, for him, a big and important step which will modify his entire future life. The step he contemplates is one that he thinks will bring him deep satisfactions. From his point of view, the application to adopt a baby has been carefully considered. The action he is taking has usually followed a long period of thought and discussion with relatives, neighbors, or family advisers—*i.e.,* doctors, lawyers, or ministers. To many who apply for a baby, the rôle of client of a social agency is not easy.[1] A barrier of reticence and shame must often be overcome before a prospective adoptive parent can put himself in the hands of a social worker. Initial self-consciousness, with its accompanying tension or defenses against anxiety, must be recognized by the social worker. Sometimes the adoptive parent may cover his anxiety by expressions of an altruistic wish to be of service to neglected childhood. It is the responsibility of the skilled social worker to understand and to evaluate not only the superficial motives that the adoptive parents present, but also the deep, underlying needs that have driven them to attempt to work out their inner dissatisfactions through the adoption of a baby.

After ruling out obviously inadequate prospective adoptive parents, there are no rule-of-thumb methods that the social worker can use to judge the suitability of a home for receiving an adoptive child. Physical fitness, absence of gross mental disease, some measure of economic security, and an adequate social and community adjustment are essential, but they offer only minimal protection to the child. Adoptive parents whose fitness on the scores listed above cannot be questioned may apply for a child for grossly improper motives, concealed behind a honeyed love of children. Such a motive may be connected with the inheritance of property or the fulfilling of the conditions of a will. This sort of client rarely comes to the attention of social workers, preferring the anonymity of nonprofessional agencies.

Other clients with motives that make them unsuitable for

[1] See "Adoption as the Community Sees It," by Mary F. Smith, in *Social Case-Work with Children,* edited by Jessie Taft. (Vol. 3, No. 1, of *The Journal of Social Work Process*). Philadelphia: Pennsylvania School of Social Work, 1939.

the responsibility of a child are those who apply for a baby as a last resort in the effort to patch up a crumbling marriage. Occasionally prospective parents apply for a baby because they think or have been told that the responsibility of a baby would be the best treatment for a wife's "nervousness."

After a good initial rapport has been established with the client who applies to adopt a baby, the gross fitness of the home and the superficial suitability of the adoptive parents can readily be established by social investigation. This investigation, as it proceeds, should bring to light any serious personality defects in the prospective parents and any evidences of marital incompatibility that, with the passing of time, might threaten the child's security. Before placing a baby, the social worker will want to be sure that all members of the child's future immediate family will welcome his admission to the family unit—especially that both the husband and the wife want him.

The social worker must be able to determine whether the prospective parents are really interested in the child they plan to adopt or whether their interests are exclusively and permanently focused on a beloved child whom they have lost and whose place they are trying to fill. Some clients apply for a child in order that a child of their own may have company. This motive does not necessarily rule them out as suitable adoptive parents, but the social worker must be very sure that the adopted child does not come into the family merely as a pet for a lonely or spoiled only child. Where there are "own children," the adopted child's situation is apt to be precarious by comparison.

Elderly couples who have waited for years in the hope of having a child of their own, and who finally accept it as inevitable that they cannot, must be considered carefully before they are given a child. Their routine of a well-ordered life will be interrupted, and rigid personalities, traveling in deep grooves, cannot accept a rude upheaval with complacency. The cheerful, companionable, well-brought-up child of their phantasy may be very different from the noisy, untidy, often cantankerous, ungrateful, flesh-and-blood hoodlum who manages always to be underfoot. On the other hand,

elderly couples who have longed for many years for a baby may, when they receive one, cling to it as an infant. They may limit its capacity for development by an oversolicitous, overprotective attitude.

When a single person applies for a baby, social workers are justified in hesitating before making a placement.[1] To attain what we regard as psychosexual maturity in our culture, the child needs close association with both a mother and a father during the early years of life. Normal Œdipus development cannot occur in an environment in which one parent figure is lacking. Masculine and feminine attributes are both found in all individuals. The boy has need of a father figure on whose personality, by the process of identification, he can strengthen his masculinity. He has need also of a mother figure to awaken and call up his love impulses and tenderness. His relationship to his mother will serve as a prototype of his future love relationships. The girl, too, needs happy relationships with both a mother and a father, if she is to attain a feminine identification and, in adult life, a tender relationship with a man that is not overshadowed by fear and aggression. The girl who becomes illegitimately pregnant is all too often a girl who, in childhood, has been denied a wholesome father-daughter relationship. The unmarried adoptive parent is in danger of investing all her (it is usually a woman) emotional interest in the child and thus smothering its individual growth. The rôle of adoptive parent is easier if there is a stable marriage as a background for the interplay of feelings.

Very often childless couples adopt a baby believing that they are sterile, and then, within a few years, have a child of their own. The psychology of this phenomenon is complex and but poorly understood. When it does occur, there are sometimes tragic results for the adopted child. Where sterility is the motive for adoption, every effort should be made by the prospective parents, and encouraged by the social worker, to elucidate in so far as possible the cause of the sterility. Medical examinations of both the husband and

[1] For an excellent discussion of this topic, see Chapters IV and V of *An Adopted Child Looks at Adoption*, by Carol S. Prentice. New York: D. Appleton-Century Company, 1940.

the wife are indicated, and in some cases consultation with a psychoanalytically trained psychiatrist will be of help.

Jenkins,[1] in discussing the investigation of the prospective adoptive home, gives the following advice:

> "Perhaps the crucial criterion is the ability of the parents to see in the child something more than a satisfaction of their own needs; the ability to recognize in the child a separate personality, with needs of its own. While some desire to relive through the child is perhaps usually present in, and normal to, parent-child relationships, prospective adoptive parents who give the clear and immediate evidence of a predominant desire to work out their own thwarted ambitions through a child should be considered unfit. On the other hand, a degree of parental pride in the achievements and accomplishments of a child is natural and desirable. It is, therefore, advisable, so far as possible, to place children with parents who will value the degree of achievement of which the children are capable.
>
> "The recognition of motives is often not easy. Prospective adoptive parents may not recognize their own motives in seeking a child, or, recognizing them, they may seek to conceal them. To estimate motives requires an adequate acquaintance with the prospective parents to sense the goals, values, and frustrations that determine their attitudes and color their lives. . . . Of particular importance is the type of family organization in which each of the prospective parents grew up and the attitude he held toward his own parents."

III.

Having determined what children are eligible for adoption in some home, and what homes are capable of rearing some child, the social worker faces the responsibility of deciding what child to recommend to what particular adoptive parents. As the child grows up and approaches maturity, it will be easier for him and for the adoptive parents if his appearance and constitutional type are not too foreign to that of the family of which he is a part. The racial antecedents of the child and of the adoptive parents should be the same or as like as possible. Physical characteristics of the true mother and father should be borne in mind when adoptive parents are being considered for a child. In a general way, the temperaments of the child's true parents should not be in complete contradiction to the temperaments of the adoptive parents. But temperaments cannot be measured, and the social worker's sensitivity and intuition must guide her evaluation of them.

[1] *Op. cit.*

Antonio came to the attention of a study home for children at the age of nine. He had been presenting serious behavior difficulties in his adoptive home since the age of six. He ran away, stayed out late, was destructive of his adoptive parents' possessions, and stole from them. His stealing had begun with rummaging through his adoptive mother's desk and bureau drawers.

Antonio's adoptive parents were middle-class, naturalized citizens of Italian birth. They lived in one of the better Italian neighborhoods of a large city. They had adopted Antonio in infancy from a Catholic maternity home, allegedly because of the adoptive mother's sterility resulting from an operation. Antonio had been a cunning, alert, responsive baby. The maternity home in which he was born kept only the sketchiest of records. His mother was known to be French-Canadian, but nothing was known of his father.

As Antonio grew older, his hair became an auburn mop and his eyes deep blue. His skin was fair, and his definitely pug nose was covered with freckles. The name of Pat would have fitted his appearance and manner far better than did the name of Antonio. From the point of view of his particular adoptive parents, he was an ugly duckling. The adoptive mother really had wanted a "Little Lord Fauntleroy" of a child as a plaything and as a possession to show off to her Italian-American friends. In the culture in which he was growing up, Antonio was an absurdity and an anachronism, and he quickly sensed this situation and reacted to it by ever more difficult behavior.

His rummaging, I think, can be explained by his unverbalized desire to find out who he was and where he really belonged. Emotionally frustrated and deprived, he resorted to stealing in an effort to find satisfaction in taking material things from his parents to replace much-needed intangibles. He was aggressive and destructive in order to punish his adoptive parents for letting him down. For both Antonio and the adoptive parents, it was an impossible situation and one that might have been avoided by painstaking selective placement.

Though there are no scientific data on the point, and though heredity may play but a slight rôle, there may be some validity to the lay concept that breeding or cultural tradition will show itself. Fiction and folklore are full of examples of the princely born who, brought up by peasants, manifests his nobility in his personality and bearing and eventually attains the position to which his birth entitles him.[1] The reverse of this situation can also be found, and many workers in the field of adoption may have had contact with what seemed to be examples of it. (The cultural tradition and personality characteristics referred to here are not to be confused with intelligence level.)

[1] See *Myth of the Birth of a Hero*, by Otto Rank. (Nervous and Mental Disease Monograph Series No. 18.) New York: Nervous and Mental Disease Publishing Company, 1914.

To what degree, if any, there may be an unconscious identification of the self with cultural antecedents will probably remain a mystery for many years. The universal "family romance," whereby the child identifies himself with phantasied parental figures—the counterparts or opposites of the reality figures with whom he lives—may be the explanation of the apparently complete lack of harmony between the adopted child's personality and his home.[1] It is seldom possible to find a child from a family of exactly the same cultural tradition to place in a home. All that one can do is avoid contrasts that are too glaring between the background of the true and that of the adoptive parents, especially if in both cases that background has been constant or characteristic for many generations.

We come now to some consideration of the technique of placement. Practice varies widely as to how much information about the background of the child should be given to the adoptive parents. In Lippman's study,[2] an attempt was made to determine how different people "engaged in mental-hygiene work deal with the problem of child adoption." He states that almost all of the answers to his question as to how much of the family history and background should be given the adoptive parents "emphasize the need to treat each case according to its needs. They find it impossible to set down any rules that can apply to all cases. For example, one parent will demand that he be given all information. Another will want to rely entirely on the judgment of the agency. Some parents appear able to accept the child in spite of any negative factors in the family background." Thirteen of those who answered his question believed in telling as little as possible, particularly in the case of material of an unfavorable nature; one told nothing; nine held the opinion that the adoptive parents should be told everything they wish to know, except the names and addresses of the true parents; one stated that he told what the child would need to know later on; and three told as much as they felt could be accepted.

[1] See "Some Aspects of the Problem of Adoption," by Florence Clothier, *loc. cit.*

[2] *Op. cit.*

Whatever the policy about giving information to adoptive parents, there can be no question but that all the pertinent facts concerning the child's true family history, his birth and medical history, and his personal history (if he is not a newborn infant) should be recorded and filed by the agency as a valuable private document. It is also the obligation of the social worker always to tell prospective adoptive parents of any pathological condition in the child's family history that is suspected of having a strong genetic basis—*i.e.*, psychosis with no organic basis, familial feeblemindedness, or epilepsy. It is also mandatory to give adoptive parents free access to full knowledge concerning the child's medical history. If a child of pre-school age is retarded in development, adoptive parents should know it, but without the label of an I.Q. A single psychological examination of a pre-school child whose environment has not been conducive to good intellectual development can be grossly misleading.

Few social workers will question these basic essentials of agency adoption practices. It is when we discuss how much more of the data included in our records we should lay before adoptive parents that we reach controversial ground. It is a question that is perhaps best answered individually, according to the educational backgrounds and personalities of the adoptive parents and also according to the philosophy and personality of the social worker concerned. There are some adoptive parents whose honesty is such that they are in an easier position with relatives and neighbors if they can say: "We adopted him through a reliable agency, so we know that nothing was found in his history that would make him an unsuitable child to grow up in our home. Our respect for the judgment of the agency has been fully confirmed by our love for and satisfaction in our child." These parents, without sacrificing their honesty—a sacrifice that children sense intuitively—can tell the child that they do not know about his own people. If the child has a burning curiosity to know more about himself, such information as can be given him is not lost, but can readily be obtained.

An adopted adolescent girl once said to me: "I know that if I thought my mother really loved me, I wouldn't care a hoot about who my own people are, but, as it is, I

know she is hiding something from me always. She knows more about me than I do, and I can't stand it." At a subsequent interview, the adoptive mother told me that for sixteen years she had been hoping that she would forget some details about her adopted daughter's true mother, who lived in the same large city. The true mother had some social prominence and occasionally her name appeared in the newspaper. The adoptive mother was terrified for fear she would let slip some bit of information that would lead to her daughter's discovering her true identity. For adoptive parents to have access to the names of real parents must often have untoward results.

To sum up, we can say with emphasis that all pertinent information should be available, that no child with a grossly pathological family or medical history should be given to adoptive parents without their full readiness to accept such a responsibility, and that what further detail is laid before them must depend on the individual situation. My personal feeling is that no adoptive parent should be prevented from obtaining pertinent information about the child for whom he assumes responsibility, but that the agency should not insist upon every adoptive parent's reading the child's entire record. I suspect that where the policy is to give out no information, an adequate history is often not available, and that where the policy is to insist upon the adoptive parents' reading the full record, there is a wish on the part of the agency or the social worker to divide the responsibility for the step that is contemplated.

After the child is placed, there is, in twenty-two states,[1] a most important protection against an obvious misplacement—namely, a probationary period before the adoption becomes final. The advantages of this in protecting the interests both of the dependent child placed for adoption and of the adoptive parents far outweigh the disadvantages which become apparent in some cases. It is argued that the uncertainty and insecurity of the probationary period vitiates the supposed advantages of an adoptive home, and that continued supervision by a social worker makes it impossible

[1] See *Adventuring in Adoption*, by L. M. Brooks and E. C. Brooks. Chapel Hill: University of North Carolina Press, 1939.

for adoptive parents to feel toward the child as they would toward their own.[1]

In regard to the first point, if so much insecurity and uncertainty exist, it may mean, not that the probationary period is at fault, but that the home is not measuring up to the child's needs. Concerning the second point, if a social worker's supervision is utterly intolerable, it probably indicates that she failed to build up a helpful rapport early in her contact with the adoptive parents.

The probationary period can serve as far more than a gross protection of the child and the adoptive parents. It can be a period of infinite value, both to the adoptive parents and to the social worker. During this time, the social worker should be helping to prepare the adoptive parents to deal with the inevitable problems that arise in the life of an adopted child. The most obvious of these is when, what, and how to tell the child of his adoption. On this subject Jenkins writes:[2]

> "Many adoptive parents seek to conceal from their adoptive children the fact of adoption. The motive for the concealment is apparently the fear that they will not be accepted as parents by the child if it learns of its adoption. If concealment were likely to be successful, the element of deception might be overlooked. Experience indicates, however, that even when the adoptive parents move to another neighborhood or to another city, the adopted child, with few, if any, exceptions, ultimately learns of his adoption. The knowledge, usually coming relatively late, from an indirect and sometimes unsympathetic source, often produces an emotional crisis in the child's life, frequently with damaging results. The estrangement of child and parents may take its origin from this crisis, sometimes without recognition by the parents of the cause. The child who has been told of his adoption when young, at the age of 4 or 5, is forearmed against this type of damage. The knowledge need not interfere with the child's sense of security in his parents; indeed, clever parents sometimes capitalize the fact to add to the child's security by pointing out that he was selected because they wanted him especially. It is highly important, in order to avoid future perplexing doubts, that an adopted child be told of his identity and given any possible favorable information about his parents."

Valentina P. Wasson's little book[3] is probably as good an introduction to the whole subject as any, if used at the

[1] See *The Adopted Child*, by E. G. Gallagher. New York: Reynal and Hitchcock, 1936.

[2] *Op. cit.*

[3] *The Chosen Baby*, by Valentina Wasson. New York: Carrick and Evans, 1939.

proper age, four to six. It will not answer the child's deeper questions as to his integrity as a person. It may well be that the strength of a child's impulse to know about his true parents varies indirectly with the strength or depth of his identification with his adoptive parents. If his identification with his adoptive family is slight, he will return repeatedly to his phantasy of his natural parents. If his identification with his family is complete, he will have little need of his true parents.

How much the child should eventually be told of his own parents is again a highly individual matter. Some contend that access to such information is a "birthright" that should not be denied the child, but the family background of many a child who has adjusted successfully and happily in an adoptive home is such that it seems to me that knowledge of it might create more distress than is justified.

For the social worker, the probationary period is of inestimable value. It serves her as a preliminary check on the vadidity of the long, painstaking work she had done in selecting the child to be adopted, the home to receive the child, and the matching of the two. The ultimate success or failure of her work, to be sure, cannot be known for years, but if she is perspicacious she can learn more from such a follow-up period of observation than from all the books and papers written. Only if she has the benefit of seeing the results of her work in the probationary period can she have complete experience in the field of adoption. Only through follow-up experience can she individually, and we as a group, learn to be less bungling and more shrewd and expeditious in our decisions as to what child to place in what home.

Adoption will remain a hazardous relationship, but it is far less hazardous for the child than its usual alternatives. Our goal must be to know more without allowing increased knowledge to limit our scope instead of broadening it.

MENTAL-HYGIENE PROBLEMS IN AN URBAN DISTRICT *

THIRD PAPER

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THIS paper is the third of a series that report the results of a survey of the mental-hygiene problems discovered in the Eastern Health District of Baltimore in 1936. The previous papers have discussed the methods of case finding, of classification, and of statistical treatment, and some of the data obtained in the study of the specific groups of psychotic and neurotic individuals. The present paper deals with the epileptics and mental deficients discovered in the study.

THE EPILEPTICS

A study of epilepsy in the general population based on data derived from sources some of which are non-medical is not entirely satisfactory. Questions constantly arise that the data are not sufficiently complete to answer. Questions as to age of onset, etiology, situation at time of onset—these and many others cannot be answered by the data available to us. Certain other questions, such as the relationship between epilepsy and social-economic status, must be left unanswered because our population of 55,000 does not furnish enough cases of epilepsy to give statistically reliable figures on these relationships. With these necessary apologies for the incompleteness of this study, we turn to what reliable data can be furnished.

The group of cases described here is made up of all the

* This study was made with the support of the International Health Division of the Rockefeller Foundation.

individuals called epileptic in any of our sources. Cases reported simply as having "convulsions" or "fits" are excluded. These were few in number, and we assumed that in an area like the Eastern Health District, where medical service is easily obtainable, cases not designated as epileptic were likely not to be epileptic in fact—that the reported "convulsions" or "fits" were incidental to hyperpyrexia in children (known to be the case in a few instances) or were of a functional nature, in which instance the case might be classed as one of hysteria. The use of these criteria leaves us open to two possibilities of inaccuracy: first, we depend partly on the lay use of the term epilepsy for the identification of our cases; and, second we exclude cases that might be diagnosed as epilepsy if observed over a period of time by competent physicians. Recognizing these possible sources of inaccuracy, we feel that our figures are minimal. It may be proper to add that our prevalence rate for the district differs but little from that obtained by C. L. Anderson in Michigan.[1]

Altogether, 126 cases of epilepsy were discovered in our area. In 51 of these cases, the epilepsy was known to be accompanied by other personality difficulties of varying severity; in the other 75, the only fact known about the cases was that epilepsy was present. Of the 126 epileptics, 11 were psychotic and three had psychotic traits. There were 15 with neurotic traits and 12 showed other forms of personality disorder. In 70 cases the intelligence status is known, and 50 of these 70 were mentally defective. This confirms the

TABLE 1.—DISTRIBUTION BY RACE AND SEX OF EPILEPTICS DISCOVERED IN 1936 SURVEY.

	Number of cases	*Rate per 1,000 of the population*		
		Crude rate	Age-adjusted rate	Standard error
Whites	88	2.07	2.09	.25
Negroes	38	3.01	2.89	.48
Males	73	2.70	2.70	.32
Females	53	1.89	1.89	.26
Total group	126	2.29	2.29	.21

[1] See "Epilepsy in the State of Michigan," by C. L. Anderson. MENTAL HYGIENE, Vol. 20, pp. 441–67, July, 1936.

common observation that mental deficiency is much more frequent among epileptics than in the general population.

The race and sex distribution of the epileptic cases is summarized in Table 1. The rate of epilepsy is higher for Negroes than for whites, but the difference is not statistically significant. The male exceeds the female rate by .81 per 1,000, with a critical ratio of 2.00.[1] The greater prevalence of epilepsy in males has also been observed by other workers. Our material does not lend itself to answering the question of how many new cases of epilepsy appeared during a year (incidence); we can say what the total number of cases present in the district was in 1936 (prevalence).

The median age of the epileptics was 22.6 years. This is less than the median age of the total population, which was 27.8 years. Cases were spread fairly evenly from school age to middle life, so that the age-adjusted rates do not differ very much from the crude rates. That there are few cases in the later age groups is probably related to the known fact that epileptics die early as compared with the general population.

The fact that the cases are spread evenly over the various age groups is of particular interest in connection with the age distribution of mental defectives. As will be shown in the next section of this paper, mental deficiency seems to be much more common in the school ages than it is in adults. This would seem to indicate that the criteria for the recognition and diagnosis of mental deficiency in the school years are quite different from those depended upon to diagnose the condition in adults. In epilepsy, on the other hand, the presence of convulsions is a sign recognized equally well whether the patient is in school or is over school age.

[1] The critical ratio is the difference between two values divided by the standard error of this difference. It is a measure of statistical significance. The probability that a given difference is a chance result decreases very rapidly with increasing critical ratio. This is shown below. Differences with a critical ratio of less than 2 are described as insignificant in this series of papers.

Critical ratio	*Probability of chance result*
2.0	One in 22
2.5	One in 80
3.0	One in 370
4.0	One in 16,000
5.0	One in 1,750,000

In summary, epileptics in the Eastern Health District occur at the rate of 2.29 per 1,000 of the general population; the disease is more common among males; and the epileptics as a group are younger than the general population, probably because they die younger.

THE MENTAL DEFICIENTS

The definition of mental deficiency was originally based upon social competency, but with the development of applied psychology, diagnosis has become more and more dependent upon the results of tests designed to evaluate the so-called intellectual functions of the personality. The rapid popularization of intelligence tests, based on the demonstration of their usefulness, especially in the field of education, has tended to make mental deficiency an inability to perform certain set tasks, rather than an inability to discharge the responsibilities of living in society.

This change in definition—from terms of social competency to terms of I.Q. or its equivalent—has extended beyond the instrument that made it possible. The tests of intelligence generally used in this country are not properly standardized for use with adults. Nevertheless, they are so used, and the results are directly compared with those secured from children of the age groups for which proper standardization has been made.

Persons who are now in school, or who have recently been in school, in large centers of population have almost all been tested, and mental deficiency, as the term is applied to this group, means, all too frequently, failure in tests. Social competency continues to be the basis of definition for most older adults, those who were out of school before the widespread use of testing. However, in the case of these older persons also, tests are often used to substantiate observation and to reduce the estimate to quantitative terms. This situation must be kept in mind constantly in evaluating statistics on mental deficiency.

Of the total of 3,337 cases active in 1936, not less than 694, or 21 per cent, were mentally deficient, but in only 375 indi-

viduals was mental deficiency the leading problem.[1] As in the case of epilepsy, the tabulations in this chapter are based on all cases of mental deficiency, whether or not this was the complaint that had brought the case to attention, the primary or leading classification.

Of the 694 mental deficients, 59 were found to be psychotic and eight had psychotic traits. Forty-six were classified as "adult neurotics,"[2] 171 showed other forms of personality disorder, and 50 were epileptic. "Psychosis with mental deficiency" as a diagnostic group accounted for 28, almost half of all the mentally deficient psychotics. In the remaining 31 psychotic cases, another psychosis had been diagnosed and the fact of mental deficiency was noted as incidental.

These findings can be expressed in another way: of the 393 psychotics and persons with psychotic traits included in the survey, 17.0 per cent were mentally defective; of the 425 "adult neurotics," 10.8 per cent were mentally defective; and of the group with other forms of personality disorder, 16.0 per cent showed mental deficiency. We do not wish to imply, however, that these ratios indicate a close association between mental deficiency and the various forms of personality disorder. It seems more likely that the large number of mentally deficient cases among those with personality disorder is an expression of the forces active in bringing individuals to attention for social case-work, psychiatric examination, and psychometric testing. In other words, a personality disorder is more likely to be discovered in a mentally deficient person than in one of normal intelligence, because the case is likely to be seen by those who are capable of recognizing the presence of deviation. Conversely, mental deficiency is more likely to be discovered in persons who come for examination because of personality disorder than it is in persons who do not stand out in this way from the general population.

The distribution of the mentally deficient individuals by

[1] See Table 9 of the first paper of this series. MENTAL HYGIENE, Vol. 25, October, 1941. p. 643.

[2] For the definition of this term, see the second paper of this series. MENTAL HYGIENE, Vol. 26, January, 1942. p. 112.

intelligence rating is presented in Table 2. Over four times as many imbeciles as idiots were found, and over four times as many morons as imbeciles. This corresponds to the findings in similar surveys elsewhere.[1] It should be remembered

TABLE 2.—DISTRIBUTION BY INTELLIGENCE RATING OF MENTAL DEFICIENTS DISCOVERED IN 1936 SURVEY

Intelligence rating	*Number of cases*
Idiots	25
Imbeciles	111
Morons	470
Feebleminded—no test	88
Total group	694

that the cases listed as "feebleminded—no test" in the table are mostly adults; they are chiefly state-hospital patients diagnosed as showing psychosis with mental deficiency, or they were placed in the group of mental deficients by the study on the basis of an unequivocal social history.

Table 3 gives the distribution of the mental deficients by

TABLE 3.—DISTRIBUTION BY RACE, SEX, AND AGE OF MENTAL DEFICIENTS DISCOVERED IN 1936 SURVEY.

Age group	*Whites*	*Negroes*	*Males*	*Females*	*Total*	*Rate per 1,000 of the general population*
0– 4	3	...	3	...	3	0.7
5– 9	33	23	37	19	56	11.8
10–14	108	131	137	102	239	43.6
15–19	75	84	96	63	159	30.2
20–24	29	9	14	24	38	7.2
25–34	61	16	32	45	77	8.1
35–44	47	22	28	41	69	8.3
45–54	30	9	20	19	39	6.4
55–64	8	1	1	8	9	2.6
65 and over	3	2	4	1	5	1.9
Total group	397	297	372	322	694	12.2

sex, race, and age, and also presents in the last column age-specific prevalence rates per 1,000 of the general population. The age distribution is characterized by a heavy concentration in the school ages. Over 4 per cent of the children in

[1] See, for example, the *Report of the Mental Deficiency Committee, Being a Joint Committee of the Board of Education and the Board of Control*, Part 4. London: H. M. Stationery Office, 1929.

the district in the age group ten-to-fourteen years were classified as mentally defective. After the second decade of life is passed, the prevalence rate drops to about seven per 1,000 (0.7 per cent) and this level remains constant until the age of fifty-five. At older ages it shows a still further decline. Very few mental defectives were discovered in the first five years of life. The median age of the whole group was 16.5 years.

The large differences between children and adults in the matter of the prevalence of mental deficiency cannot be adequately explained by attributing them to the known higher death rates among the defectives. It will be shown later that the decline is largest among the morons and smallest among the idiots. The opposite should be true if differential mortality were an important factor, since death rates are highest at the lowest levels of mental deficiency. The chief reason for the higher prevalence rates of mental deficiency among children seems to be, as we have indicated above, the difference in the conditions of case finding and in definition. Mentally defective children are discovered in the schools of Baltimore by routine testing, whereas adults are brought to observation only when they have become manifest social failures. Apparently many individuals who, as children, were or would have been found to be mentally deficient, in later life become useful and well-adjusted citizens who do not require special care, attention, or supervision.

The sex ratio of the mentally deficient group as a whole is seven males to six females. There is an excess of males up to twenty years and of females after that age. We are inclined to accept the predominance of males among the younger cases as a true picture of prevalence, whereas the predominance of women among the older cases seems to be due to the fact that women are tested more often than men and are included in the records of our sources in connection with child-placement cases, sterilization, and so on. The husband or father escapes psychiatric or psychometric study because he is less easily available.

In view of the great differences between children and adults in the significance of mental deficiency, it seems rather pointless to compute a prevalence rate for the total popula-

tion. It is a more useful procedure to present two sets of rates—one for the quinquennium ten through fourteen years —which is covered best and which may be assumed to be representative of the conditions in childhood—and another for the population aged twenty years or over. These data are presented in Tables 4 and 5. As has been pointed out

TABLE 4.—DISTRIBUTION BY INTELLIGENCE RATING, RACE, AND SEX OF MENTAL DEFICIENTS AGED TEN TO FOURTEEN DISCOVERED IN 1936 SURVEY.

Intelligence rating	*Number of cases*	*Rate per 1,000 of the population*	*Standard error*
Idiots	4	.7	.4
Imbeciles	14	2.6	.7
Morons	217	39.6	2.6
Feebleminded—no test	4	.7	.4
Total group	239	43.6	2.8
Whites	108	26.1	2.5
Negroes	131	98.2	8.1
Males	137	50.5	4.2
Females	102	36.8	3.6

TABLE 5.—DISTRIBUTION BY INTELLIGENCE RATING, RACE, AND SEX OF MENTAL DEFICIENTS AGED TWENTY OR OVER DISCOVERED IN 1936 SURVEY.

Intelligence rating	*Number of cases*	*Rate per 1,000 of the population*	*Standard error*
Idiots	10	.28	.09
Imbeciles	67	1.89	.23
Morons	86	2.43	.26
Feebleminded—no test	74	2.09	.24
Total group	237	6.68	.44
Whites	178	6.52*	.49
Negroes	59	7.23*	.97
Males	99	5.72*	.57
Females	138	7.62*	.64

* Age-adjusted rate.

before, the prevalence rates of all grades of mental deficiency are higher among the school children than in the adult group. This difference is very large for morons, even if all adults

in the group "feebleminded—no test" are assumed to fall into this category, but it is small and statistically not significant for idiots and imbeciles.

The sex ratio happens to be 4:3 in both groups, but whereas the boys have a higher rate than the girls, the adult women have a higher rate than the adult men. Both differences are statistically significant, with critical ratios of 2.45 and 2.20.[1]

The prevalence of mental deficiency among Negro children, as shown in Table 4, is very high—almost one out of ten—and the rate is nearly four times as high as in whites. In the adult group the two races show almost equal prevalence rates for mental deficiency. This finding suggests that certain behavior patterns that would be called socially incompetent in whites are accepted by social workers as within normal range in colored persons.

In the school-age group at least, our data on mental deficiency in the district are sufficient for analysis by family income. These data are not presented here, however, because it was felt that they would not contribute materially to knowledge about the social-economic differentials of the I.Q. Numerous studies on that subject are already available, done on large samples and with more adequate testing procedures than are available to us.[2] The results of such studies show uniformly that the lower social-economic groups contribute more than their share of mental deficiency.

[1] This paragraph may form the basis for a discussion of certain problems concerned with statistical significance. In both cases—the predominance of males among the mentally deficient children, and of females among the mentally deficient adults—the critical ratio indicates that the findings are not due to sampling variation. In the first case, as stated above, we feel that this male predominance is actually due to the fact that males are more likely to be mentally deficient than females, for we know that females and males had an equal opportunity to be tested by the school situation as well as by special tests. In the second instance, however, we believe that the significant difference between the sexes is due to the selective factor of the mother's greater availability for testing. In the first case, the difference has to do with the presence or absence of mental deficiency; in the second, with a factor more related to social custom and demands of work hours than with mental deficiency. The misinterpretation of critical ratios in such situations as this has tended to throw statistical procedures in connection with psychiatric data unfairly into disrepute.

[2] Much of this material is summarized and critically appraised in *Dynamics of Population*, by Frank Lorimer and Frederick Osborn. New York: The Macmillan Company, 1934. Chapter 8.

In summary, mental deficiency is present in about 4.4 per cent of all children between ten and fourteen years of age in the Eastern Health District, and is almost four times as prevalent in Negro as in white children. Probably because of the different criteria used for its discovery, mental deficiency is found to be much more common in children than in adults, and this difference is smallest in the idiot group and largest in the moron group. In the children it can be demonstrated that mental deficiency is slightly more common in males than in females.

THE INDEX OF CASE FINDING

On several occasions in this series of papers it has been suggested that the various social-economic groups of the population were not covered equally well by some of our sources. This proposition will now be examined in greater detail.

Clinics and social agencies serve chiefly the needs of the less prosperous, and there can be no doubt that among the cases drawn from these sources the lower-income brackets are overrepresented. In the upper strata private physicians are available and social workers are not called in; this must lead to a deficiency of cases from this group in our material. Juvenile delinquents and—at least in certain types of offense—adult law-breakers are also more likely to come to official attention if they are poor than if they are in better circumstances. On the other hand, it is felt that the inclusion of both public and private mental hospitals has resulted in a reasonably uniform coverage of all social-economic groups as far as psychotics in need of institutional care are concerned.

It is clear that this unequal coverage not only affects direct comparisons between different social-economic groups, but that it also enters into the relationships between groups otherwise defined, provided they be on different social-economic levels. Thus it must be remembered that the Negroes in the district are almost exclusively found in the lower income groups and that, therefore, mental deviations must be expected to be more completely reported among them than among the whites, whose incomes show a wider range.

Another point at which the problem of selection appears

very distinctly is in the Jewish group. The social agency that serves most of the Hebrews of the district appears to have paid especial attention to personality problems. This factor should make for the discovery of a greater proportion of personality disorders among the Hebrews.

In order to get some idea of the magnitude of these selective forces, we have worked out an "index of case finding," derived in the following manner:

We make the assumption that the number of cases reported in the National Health Survey by their relatives or by themselves as insane, nervous, epileptic, or in similar terms, represents a constant proportion of the "true" total number of psychotics, adult neurotics, and epileptics in the district. These groups were chosen because in the aggregate they most nearly correspond to the layman's conception of mental and nervous diseases. To be sure, not all cases whose illness was active in 1936 were reported in the survey. The failure to report might be due to a variety of causes. The condition may not yet have been apparent; it may have been unknown to the informant, or the informant may have been unwilling to reveal it; or may have reported it under the name of some somatic disease. It is obvious that level of intelligence and of education might influence the extent and the correctness of reporting. Nevertheless, every informant had the same opportunity to report, and we make the assumption that the proportion reported is the same for all groups. We hasten to add that, while this assumption is plausible, there is no way of verifying it at present.

The assumption made, the total number of cases found by all sources in any section of the population and identified in the household rosters of the National Health Survey is divided by the number of cases reported as insane, nervous, and so on, for the section in question. We thus arrive at a figure that indicates the completeness of coverage. This figure we have called the "index of case finding." Perhaps a fictitious example will make the procedure clearer: Suppose our 44 sources found 50 cases in Block No. 14. The National Health Survey enumerator received 25 reports indicating mental illness in that identical area. The index of case finding, then, is computed 50/25=2.00, which index would show

that the coverage of our sources was exceptionally good in that area. In using the index, Block No. 14 of this example may be replaced by any other grouping, whether on the basis of geography, race, income, family size, and so forth, so long as the required comparable figures can be obtained.

Table 6 presents some of the indices we have calculated as

TABLE 6.—PSYCHOTICS, ADULT NEUROTICS, AND EPILEPTICS FOUND IN ALL SOURCES AND IDENTIFIED IN NATIONAL HEALTH SURVEY; CASES REPORTED IN NATIONAL HEALTH SURVEY AS INSANE, NERVOUS, AND EPILEPTIC; AND INDEX OF CASE FINDINGS BY RACE, ETHNIC STOCK, SOCIAL-ECONOMIC STATUS OF HOUSEHOLD, RELIEF, AND INCOME.

	Cases found in all sources identified in National Health Survey	*Cases reported in National Health Survey*	*Index of case finding*
Total group	658	418	1.57
Whites	539	356	1.51
Negroes	119	62	1.92
Hebrew	89	36	2.47
Non-Hebrew whites	450	320	1.41
Social-economic status:*			
Unskilled labor	56	38	1.47
Semiskilled labor	155	98	1.58
Skilled labor	168	114	1.47
Clerical	74	49	1.51
Professional and business	62	41	1.51
Unclassified	24	16	....
Relief and Income:*			
Relief	101	53	1.91
Non-relief under $1,000	189	130	1.45
$1,000 to $1,500	150	101	1.49
$1,500 to $2,000	51	41	1.24
$2,000 and over	38	25	1.52
Unknown	10	6	....

* Whites only.

illustrations of how the procedure may be used. The total number of psychotics,[1] adult neurotics, and epileptics found in the district is 928, excluding duplications. Of these, 658 were identified in the rosters of the National Health Survey. The difference—270 cases—is made up of Census-H and non-census individuals, as defined in the first paper of this series,[2]

[1] Including persons with psychotic traits.

[2] *Loc. cit.*

who of course had to be omitted from these calculations. Most of them had probably moved into the area after the canvass had been made, or they had been inmates of institutions for more than a year and were for this reason not enumerated. Of the remaining 658 cases, 58 were reported as insane or by a synonymous term; 304 as nervous—including nervous breakdown, and so on; 41 as epileptic; and 15 in other terms. The total number reported was 418. The index of case finding, therefore, is 658/418 or 1.57 for the district as a whole.

As was to be expected, the index of case finding is considerably higher for the relief than for the non-relief population. Above the relief level no conspicuous differences are found, nor do they appear when the classification of social-economic status of household is based on occupational data. The index of case finding is higher for Negroes than for whites in accordance with the Negroes' lower economic status, and it is much higher for Hebrews as a group than for the non-Hebrew whites, thus bearing out our impression that the Jewish agency operating in the Eastern Health District knew its clientele more thoroughly and recorded its facts more completely than did the other social agencies serving our population.

A cross-tabulation of income and ethnic stock furnished further interesting results. The little group "Hebrew-Relief" has an index of case finding of 3.57. This ratio is based on a total of 25 cases and not too much weight should be attached to it It suggests, however, that if as much were known about the population of the district as a whole as is known about the "Hebrew-Relief" group, about twice as many individuals in the combined group of psychotics, adult neurotics, and epileptics would have been found as are actually on file. The combined prevalence rate of these three reaction types would be about 3 per cent of the population, rather than the 1.6 per cent actually recorded. The majority of the undiscovered cases undoubtedly belong in the neurotic group.

The index of case finding, as it has been computed, applies as such only to the aggregate of psychotic, adult neurotic,

and epileptic cases. Unwarranted generalizations should be guarded against. At present we see no way to develop similar indices for other types of personality disorder because the National Health Survey does not furnish data on behavior patterns not regarded as sickness by the laity. There is no reason to assume that either the magnitude or the direction of variation in coverage is necessarily identical in all the different groupings of our classification.

In some of the ensuing papers, especially in the study of geographical localization of cases, the index of case finding will be useful in avoiding errors in interpretation. It is introduced at this time in the series rather than at the beginning because we felt that a certain familiarity with our material was necessary before its significance in the study could be fully appreciated.

SUMMARY

This third paper on the results of a survey of mental-hygiene problems in the Eastern Health District of Baltimore (population 55,000) allows the following conclusions:

1. Epilepsy is present in over two per 1,000 of the general population. It is more prevalent in males than in females. From school age to middle life, the disease is fairly equally distributed in all ages. The median age of epileptics is less than the median age of the total population.

2. Mental deficiency is found much more often among children than among adults because of differences in the criteria for diagnosis in the less severe types of deficiency. Morons are four times as common as imbeciles and imbeciles four times as common as idiots. Negro children show a far higher prevalence of mental deficiency than do white children.

3. The use of an index of case finding, the technique of which is demonstrated, indicates that coverage by this survey is better among groups of lower social-economic status than in more privileged groups.

WHEN IS PLAY NOT PLAY?

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THE boy was found to be very insecure and unhappy. Several concrete recommendations were made, only one of which need be discussed in the present article. It was a good recommendation except for one detail—the parents did not understand what it meant. The recommendation was that the boy needed to play and that opportunities for play should be provided.

The boy had been a sickly child. Long years before, a doctor had warned the mother that she must be careful not to let him overexert. In coöperating with a doctor, the mother had always been ready to strain at a gnat. She had required her delicate offspring to lie down much of the time, while other boys of his acquaintance had been out playing. She had kept this up for a long time after she had been out of touch with the physician who had made the original recommendation.

The boy was thirteen now, tall for his age, but a childhood of *oversupervision* (I prefer the term to *overprotection,* though in this case it amounts to the same thing) had left him weak, dependent, and timid. In the rough-and-tumble of casual play, he was no match for boys a year or two younger, and as for athletics, he had had no opportunity to develop skill in any sport that called for muscular exertion. He had made sporadic attempts to play baseball, but he could not throw straight, and he could not catch a fast ball, and he could not hit. He did not want to dodge, but the movement was involuntary. He was deeply ashamed of his weakness. It did not help matters that his father was ashamed of his dodging—thought his son was cowardly. So every time the boy made an attempt at something athletic, he was frustrated and humiliated. He had developed an anguished dread of the athletic situation.

But upon hearing that the boy needed a chance to "play," both parents resolved that he should have it, whether he

was willing or not. So his father sternly commanded him to "play" ball with boys his own age. He obeyed bitterly, rebelliously, hopelessly. The humiliation of it was almost more than he could stand. The realization of his physical inferiority was forced upon him more and more deeply.

Other boys were not always available for purposes of "play." Possibly they may have sensed that to Jackie their companionship was about as welcome as a *Blitzkrieg*. But when other boys did not show up to play with him, Jackie's mother and father valiantly strove to fill the bill. They had quoits, and although Jackie much preferred to read or tinker, when father came home, tired from the day's work, he did his duty and played quoits with Jackie. He was anxious that the boy should develop some skill. So he criticized everything that the child did. "Playing" with his parents became even more nerve-racking than "playing" with other boys.

One consolation he had had throughout most of his life. He was a bright boy and he knew it. Like many people who feel inadequate, Jackie gave a superficial impression of extreme conceit. It was not that he overestimated his knowledge, but that on certain subjects in which he had read up, he really did know more than some of his school-teachers, and he could not resist the temptation to display his superior knowledge in unwise ways and at unwise times.

Whether for better or for worse, his bubble of intellectual superiority was eventually pricked. Then he felt insecure indeed. It was almost as if the bottom had dropped out of his universe. Consolation he had none, but there was still an escape mechanism through which he could forget his miserable self. There was one sedentary game in which he had developed skill. He had played it with a few adult friends, and had taught it to the one and only friend of his own age that he had—another pallid, timid, "unsocial" boy like himself. Whenever possible, he escaped from father and mother and their determination to "play" quoits with him, sought the companionship of his boy friend, and won repeatedly at the game which he had taught the friend. Symbolically, in discussion of this sedentary game, he revealed the hidden themata of his personality. He spoke of a "strong" game, a "rugged" attack, an "aggressive

move," as he sat comfortably across the table from the young friend who understood him.

Security with a sympathetic friend, and symbolic aggressiveness under conditions where the outcome did not matter! This was play indeed, if anybody could have realized the fact.

Unfortunately mother read in the paper that a tournament was to be held. Jackie did not wish to compete, but mother insisted.

"I just made up my mind," she explained afterwards, "that he was going to get a little social life."

He played and won. He was the junior champion of his locality. It was thrilling, but Jackie gave no outward sign of elation. He had suffered before for showing conceit. There should be no bubble this time. Then no one could prick it. He took his victory calmly—almost too calmly. But he began to delve deeply into the literature of his favorite game. Whereas he had once browsed in this literature casually and for the sake of the oblivion such reading afforded him, he now studied intensely and with a purpose.

He played in the state championship match and lost—but he had attracted the attention of men who were expert players. One of them told him that he had the makings of a master. Enthusiastically, he redoubled his efforts to perfect himself in the game. No banker at golf ever played with greater earnestness.

"I think it is a nice game," said his mother, "and I was glad to have him learn it, and I hope he keeps on and plays an occasional game for recreation. But this is not play. He is studying it harder than he ever studied his school work."

So frustration appeared on the scene in a new guise. This time, it was the boy who was determined to play and the parents who were bent on stopping him. True, much of his activity in connection with the game of his choice consisted in reading the works of acknowledged masters at the sport. But what of that? To the boy, this study was simply preliminary. He conceived it as an essential preparation for competitive play of a high order. In fact, the men who predicted his future as a player had told him that the way to begin was to read up on famous games

and practice trying to repeat the essential moves. This he did, sometimes alone, sometimes in the companionship of his one friend, sometimes with a young man who played the same game pretty well, and sometimes in a boys' club which met one evening a week.

As his interest in the game deepened, his parents' distress increased. For one reason and another (some of them excellent reasons) they prevented him from seeing the one boy of his own age whom he liked. They found occasion now and then to forbid him to go to the boys' club. Yes, it did meet in the evening during the school week, and most of the boys were older, and it met quite a distance from his home, so that he had a long bicycle ride there and back. But these reasons might have been weighed before he was allowed to join the club in the first place. Never able to predict when he might be forbidden to go to the club, he stopped going, "of his own accord." That is one way to thwart adult tormenters. Forbidden the society of his young friend, he could still practice his game alone. Practicing his game alone became almost an obsession.

Then the parents became thoroughly frightened and correspondingly determined to put an end to the situation. The game became one of the foci of family conflict—not the only one to be sure, but the most bitter one for a while.

Jackie is not a bad boy. His rebellion, though silent and sullen and bitter for a while, was temporary. He has dropped his favorite game—dropped it like a hot potato.

Once more he is trying to please his parents.

As he remarked to the writer, "My parents are so changeable that I might as well go to extremes with them."

Query: How can earnest, coöperative, unimaginative parents be helped to see what play is and what it is not?

STEWART PATON

DR. Stewart Paton, distinguished physician, teacher, and pioneer in the field of mental hygiene, was born in New York City in 1865, the son of William and Anne Staveley (Agnew) Paton, and died at his home at St. James, Long Island, on January 7, 1942, at the age of seventy-six.

A graduate of Princeton in the Class of '86 and of the College of Physicians and Surgeons (Columbia), Class of '89, Dr. Paton pursued postgraduate studies abroad. For a time he was engaged in biological studies at the Zoölogical Station in Naples with Anton Dohrn. He worked with Obersteiner in Vienna and attended Krafft-Ebing's courses in psychiatry prior to coming to Baltimore. As associate in psychiatry at Johns Hopkins, Dr. Paton pressed for better laboratory facilities at the hospital and medical school, and for the more effective teaching of psychiatry, for many years before the Henry Phipps Psychiatric Clinic was established. Actually he played no small part (through his influence upon Doctor Welch) in securing from Mr. Phipps the funds for the establishment of that clinic. For some years he was Director of Laboratories at the Sheppard and Enoch Pratt Hospital, at Towson, Maryland, devoting himself there to studies in neurophysiology and neuropathology.

Dr. Paton was an early champion of mental hygiene, which undoubtedly came to be his greatest professional interest. As student adviser and lecturer in neurobiology at Princeton University, he established really the first university mental-hygiene department for the benefit of undergraduate health. Later, 1926–1928, he continued this pioneering work at Yale University.

Referring to the development of this deep and fruitful interest, Dr. Paton in a recent letter said, "I switched from Psychiatry to Education as it seemed to me that unless students and the public were educated in human ways of living, there would be no way of checking the spread of the

emotional and mental disturbances that are now (1941) the greatest existing menace to democratic forms of government and to civilization."

During the Princeton years, he lectured also in psychiatry at Columbia. At Yale he held the post of consultant in mental hygiene and lecturer in psychiatry. Dr. Paton was also instrumental in introducing better psychiatry into our army during the World War, the selection of Thomas W. Salmon and of Pierce Bailey by Surgeon-General Gorgas having been recommended by him. His widely used textbook, *Psychiatry,* was published in 1905. Other papers and publications of high merit followed, among them the following books: *Education in War and Peace* (1920); *Human Behavior in Relation to the Study of Educational, Social, and Ethical Problems* (1921); *Signs of Sanity and the Principles of Mental Hygiene* (1922); and *Prohibiting Minds and the Present Social and Economic Crisis* (1932).

In 1892 Dr. Paton married F. Margaret Halsey. She and their three children, F. Evelyn, William, and R. Townley, survive him.

He was a trustee of the Carnegie Institution of Washington, a trustee of the Josiah Macy, Jr., Foundation, a fellow of the American Association for the Advancement of Science, and a member of the American Philosophical Society, of the American Neurological Association, and of other scientific societies. In 1919 he was made President of the Eugenics Research Association. He was also a member of the Century Club of New York City.

Dr. Paton was a man of broad interests, keen, alert, stimulating, and highly regarded by his associates. Possessed of great charm of personality, he had a host of friends. There have been but few psychiatrists who have contributed throughout a long life an influence so fine and so constructive.

ROSS M. CHAPMAN

BOOK REVIEWS

ESCAPE FROM FREEDOM. By Erich Fromm. New York: Farrar and Rinehart, 1941. 305 p.

Modern man has achieved freedom from many earlier bonds that once gave meaning and security to life. But he has been left puzzled, fearful over what to do positively with all this new advantage. He cannot bear the isolation of this freedom. Hence he is driven into new bondages, of which Fascism is the outstanding tragic instance. This is the theme of a scholarly study, by a German psychoanalyst now on his way to citizenship among us, of the interactions between psychologic and sociologic factors in to-day's life.

The book is notable for many reasons. It would be worth reading if only for its criticisms of Freud. Dr. Fromm acknowledges his debt to the master, but is at the same time keenly aware that other forces quite as important as sex operate in the psyche. For example, flight to authority or to the magic helper need not be due to the continuation of original sexual attraction to a parent; it may arise from the anxieties due to the thwarting of other expressions of the child's expansiveness and spontaneity. Then, as Freud realized later in his career, there are impulses to destruction which are every whit as basic as those of sex. Moreover, if "bad" impulses are repressed, "good" ones, too, are subject to similar restraint. In our society many creative emotions are discouraged early—with the result that "millions of emotion-starved customers are fed on the cheap and insincere sentimentality of the movies and popular songs." Not least is the criticism that where Freud envisages man as fundamentally antisocial and society as largely an agency of repression, Dr. Fromm looks upon man as biologically a social creature, too, with society offering encouragement to creation by stimulating the individual's creative potencies.

Dr. Fromm is a much better sociologist than his former master. He has done more studying of the social conditions by which individual behaviors are as much influenced as by the native drives. The psychologic problem cannot be separated from the material basis of human existence, from the economic, social, and political structure of society. For this reason the book has much to offer toward a psychoanalytic *social* psychology. Where Freud centered his psychology around sex and Karl Marx his around economic motivations, Fromm sees that the need to avoid aloneness is as urgent a force as any studied thus far; and although he by no means ascribes the rise

of Fascism to this one fact, his illustration of his thesis out of the behavior of Nazis gives more than academic importance to his plea.

His main contentions are as follows:

> "The isolated individual in modern society has become free from all bonds that once gave meaning and security to life. The individual cannot bear this isolation; as an isolated being, he is utterly helpless in comparison with the world outside and, therefore, deeply afraid of it; and because of his isolation, the unity of the world has broken down for him and he has lost any point of orientation. He is, therefore, overcome by doubts concerning himself, the meaning of life, and eventually any principle according to which he can direct his actions. Both helplessness and doubt paralyze life; and in order to live, man tries to escape from freedom, negative freedom. He is driven into new bondage. This bondage is different from the primary bonds, from which, though dominated by authorities or the social group, he was not entirely separated. The escape does not restore his lost security, but only helps him to forget his self as a separate entity. He finds new and fragile security at the expense of sacrificing the integrity of his individual self. He chooses to lose his self since he cannot bear to be alone. Thus freedom—as freedom *from*—leads into new bondage" (p. 256).
>
> "Man, the more he gains freedom in the sense of emerging from the original oneness with man and nature and the more he becomes an 'individual,' has no choice but to unite himself with the world in the spontaneity of love and productive work, or else to seek a kind of security by such ties with the world as destroy his freedom and the integrity of his individual self" (p. 22).

Why "modern" man? The author takes us back to the Middle Ages in order to bring home to us what highly important changes have taken place in men's ways of behaving. Just as a child gets a marked sense of "belonging" from his dependence on his home, so medieval man felt entirely sure that he "belonged" in ways no longer so common. Everybody then had a distinct and recognized rôle in the social order. "He was peasant, artisan, knight, and not an individual who happened to have this or that occupation." More often than not he always lived in the place where he had been born. His social status was fixed by law. Often his garb and food were so prescribed. Laws regulated the prices at which goods and services were to be sold. Guilds held members to strict account for guild standards. And people were members of a Church which no man dreamed of leaving.

The interplay between the Reformation and modern capitalism changed all this. How Protestantism detached the individual from very influential group membership is a familiar story. Less familiar is the fact that for multitudes this particular freedom brought an "emphasis on the wickedness of human nature, the insignificance and powerlessness of the individual, and the necessity for him to

subordinate himself to a power outside of himself." The combination fits in neatly with important phases of the Hitler ideology, although of course the latter rejects the Protestant emphasis on freedom and moral principles. The Reformation did something, along with other forces, to develop the individual's feeling of alone ness and of inability to stand certain resulting inner conflicts. (The author might have cited such testimony as that of Carl Jung,[1] who states that Catholics constitute a markedly small proportion of his patients and that modern man suffers not because he has lost an earlier faith, but because he has not yet found another to replace it.)

In a chapter indebted to Sombart and Weber, Dr. Fromm points out how the individualizing influence of the Reformation went along with a similar influence exercised by the rise of modern capitalism. The economic organization of medieval society had been relatively static. Illustrations of this fact have already been given. Competition, for example, was strictly regulated by the guilds. The Church insisted on subordinating economic interests to the real job of life—namely, salvation—and did at least something to remind its people that business must obey the rules of morality. The appetite for economic gain was held in partial check. But modern capitalism unleashed this appetite in great numbers of individuals by holding out huger temptations to more people. Contrast, for example, the petty, inter-town affairs of medieval commerce with the national and international commerce that grew up rapidly in the fourteenth and fifteenth centuries. Contrast the marked mobility of modern workers with the fixity of medieval serfs and town laborers.

In all these changes many individuals could rise economically by their effort—but they paid a price. They no longer had the security of the traditional status. Unregulated competition brought harm as well as benefit. It brought the freedom of modern democracies, with all their mixed good and bad. Particularly did the change remove man from his fixed place in a closed world. Not everybody to-day enjoys the wealth or the power of those who got so much of both from these modern opportunities. For multitudes, without the support of the older faith, the world has become not merely *limitless*, but in large part for that reason *threatening*. The new freedom created deep feelings of insecurity, aloneness, doubt, anxiety. It gave freedom *from* old ties without offering better ties than the ones which multitudes have grasped to their own hurt.

Here the Freudian in Dr. Fromm throws light on the relationship of all this to the rise of Fascism and to the danger, by no means

[1] See his *Modern Man in Search of a Soul*. New York: Harcourt, Brace, and Company, 1933.

fantastic, that lands as yet immune to this plague may also be afflicted. Inner insecurity creates conflicts which in turn create their own mechanisms of escape. Among these mechanisms the author confines himself chiefly to sado-masochism. Students of psychology recognize easily the significance of the flight of bewildered, insecure millions to authority: "You decide for me. Lead and I will follow." What is a bit less familiar is the polarity between the masochistic and the sadistic impulses. The conduct of Nazis, at once cringing before superiors and harsh to inferiors, is notorious. Fromm reminds us how both types of impulse express a need—the need of their object to satisfy the craving. The masochist needs the magic helper or other authority. But no less does the sadist need an object, not to destroy it, but to permit the continued venting of his will to dominate and to torment. The fact, for instance, that the Third Reich did not expel all its Jews, but even put obstacles in the way of their leaving, is one illustration of how the impulse works. "The essence of the 'authoritarian' character is the simultaneous presence of sadistic and masochistic drives."

Warnings to our own democracy at once come to mind. Here, too, multitudes feel the insignificance and powerlessness of the individual. Here, too, the sense of isolation drives individuals to seek escape in blind conformity, in utter submission, if not as yet to some Leader, then to uncritical crowd opinion. Though the author does not say so, the eagerness with which poor whites in the South lynch Negroes or bulldoze them indicates that the sadistic impulses are not entirely unknown over here, too.

The book closes with a strong plea for an education that will really encourage original thinking—original in the sense not of being new, but of being more genuinely the individual's own—and the creativeness and spontaneity for which not only the particularly artistic long. The warning against breeding the destructive discontents attending on economic frustration will stand frequent repetition. So will the hint that workers need a more active participation in determining their own life and the behavior of society than they get from casting a vote once a year.

Readers of this provocative and well-written book will differ in their criticisms. Some will question whether the dread of aloneness is as operative in Americans as it is in the Europeans whom Dr. Fromm probably knows more intimately. Many Protestants will state in different terms the problems raised by the Reformation. Other students will question whether Sombart, Weber, Tawney, do not overemphasize the Calvinistic freeing of business from ethical restraints. Others will want a better leading for freedom than the

idea, "There is only one meaning of life: the act of living itself." Felix Adler, for instance, used to plead for this ideal of work—among other activities of free spirits: "So do you work in the world that others do their work better," or, "Test your own quest of freedom by what it does to release the distinctive gifts in fellow men."

All these criticisms and more are likely to greet any one who touches so vast a human problem as that which Dr. Fromm has opened up. But in writing *Escape From Freedom,* he has performed no slight service.

HENRY NEUMANN.

Brooklyn Ethical Culture Society.

AMERICA'S LAST KING. By Manfred S. Guttmacher, M.D. New York: Charles Scribner's Sons, 1941. 404 p.

This book is a singular enterprise. In it Dr. Guttmacher, after a most careful search among the records of the period, has set down a full case history of the several attacks of insanity suffered by King George III of England. Through the clinical account of George's illnesses, a clear picture can be seen of the economics, the problems of politics and of international relations, that studded his turbulent reign. The book is a cross between an excellent biography and a study of the effects of a psychiatric illness on affairs of stage—or, more properly, the effect of affairs of state on a mentally ill ruler.

George's life came in a period rich in pamphleteers, in pithy writers, and in sharp-tongued wits. The quoted material is always interesting, frequently amusing, and often significant. The political intrigues of the court are carefully traced as they affected George, and if fault there be in this, it can be said to reside in these political details.

Guttmacher has traced an interesting picture of the development of a personality that blossomed into a series of psychotic episodes later in life. He shows, through an exposition of George's early life, how the dull-appearing royal youth, nurtured in a rough atmosphere empty of love, developed into a monarch in spite of the general air of contumely in which he lived as a boy. His apparent dullness, his reputation for indolence, his general introversion remained with him through his twenties, gradually giving way to some degree of maturity, albeit at the price of a distorted personality.

When he ascended the throne at twenty-one, George was a gross, manneristic person, obsessive in his thinking, insecure, but anxious to satisfy his subjects as an English king. Under the hammer blows of cabinet difficulties and the sarcastic taunting of his subjects, he

managed to rule with relative skill until the last half of the eighteenth century. He reacted to these pressures fairly well until middle life, when he developed symptoms of vacillation and recurrent depressions, with serious agitation and restlessness. Near the end of his life, cerebral arteriosclerosis complicated the picture.

Particularly interesting is the picture of King George's daily life, his obstinacy, his interest in detail, the "microscopic attention" that he gave to all of his affairs, and the trend toward poverty in living that alternated with expansiveness, in accordance with his alternating sub-depressive and sub-manic moods. One could quote from the material of George's critics endlessly. All of it is amusing, and some of it barbed, aimed at the mental inefficiency of the Hanoverian line that had been inflicted on the British people. For example, as Wellington said, they were "the damnedest millstone that ever hanged around the neck of any government."

The book also gives an excellent picture of the practice of psychiatrists in England in the 1780's, and rehearses the somewhat familiar controversy as to the merits of bleeding, scarification of the scalp, restraint, and cathartics, that was rampant in the treatment of the insane in England during that time. The names of Drs. Willis, Warren, Monro, and Haslam stand out in this period of psychiatric history.

The book is well written, though perhaps a trifle over-detailed, and marred but slightly by fortuitous psychiatric observations, such as that on page 115: "Freudian disciples who, with their sexo-centric emphasis, postulate Œdipus conflicts as the basis of so many mental disorders." On the whole, it can be recommended to any reader with an interest in the historical aspects of psychiatry. In the opinion of this reviewer, it is particularly valuable as a document for students of English history, especially since Dr. Guttmacher ransacked the Royal Archives in the library of the Royal College of Surgeons in preparation for his work.

W. Bromberg.

Reno, Nevada.

The Care of the Psychiatric Patient in General Hospitals. By Franklin G. Ebaugh, M.D. Chicago: The American Hospital Association, 1940. 79 p.

In this concrete monograph, the author ably demonstrates the necessity for a psychiatric service in every modern, well-equipped general hospital.

He first focuses the attention of the reader on the vastness of the problem. Next he discusses the advantages of a psychiatric ward to

the general hospital and the need for the psychiatric education of nurses, interns, residents, and physicians. Finally he gives definite suggestions for the selection of a psychiatric staff, the equipment of the physical plant, and the development of adequate nursing personnel. He also surveys the various methods of psychiatric study and treatment of mental disorders, especially by means of psychotherapy. Emphasis is laid on the very necessary spirit of coöperation between the department of psychiatry and the other major subgroups of medicine.

One of the many interesting facts that the author presents is that 4 per cent of the population at some time in their lives become custodial patients, 16 per cent develop severe neuroses, and 32 per cent become mildly neurotic. In spite of these facts, only 63 of the general hospitals in the United States, out of a total number of 4,302, will knowingly and honestly admit psychiatric patients. Many hospitals must, therefore, admit the mentally ill without really facing the problem openly. In 1930 there were 161,391 empty non-revenue-producing beds in general hospitals, while practically all hospitals for mental diseases were overcrowded.

From the standpoint of the patient, psychiatric care in a general hospital offers early treatment and cure, complete care of every condition, and freedom from the stigma associated with legal commitment. From the point of view of medicine, psychiatric consultation offers a better understanding of the personality as a whole and consequently better treatment and a shorter period of hospitalization. Psychiatric consultation and treatment ought, therefore, to be easily available in every modern hospital. This fact alone should establish the necessity for a department of psychiatry.

The author's outline of the methods of psychiatric study, as well as his suggestions for treatment, is necessarily short and sketchy. He does, however, give the hospital administrator some insight into modern psychotherapeutic procedures.

The monograph will be exceedingly valuable to all those interested in hospital management. It gives the psychiatrist a coherent outline of the essential requirements for the establishment of an effective psychiatric ward or unit. Finally, it may serve to focus the attention of all physicians on what modern psychiatry can offer their patients. The book, therefore, fulfills its purpose of attempting to change the old-fashioned attitude of some physicians who still regard psychiatry as a thing different and apart from the rest of medicine.

CLARENCE D. NEYMANN.

Cook County Psychopathic Hospital, Chicago.

A History of Medical Psychology. By Gregory Zilboorg, M.D., in collaboration with George W. Henry, M.D. New York: W. W. Norton and Company, 1941. 606 p.

One of the indices of maturity in a science is a serious interest among its followers in the history of that science—how it came into being, how its principles have developed, and what contributions those who have gone before have made to its growth. As we reflect upon the youth of the specialty of psychiatry, we may, then, not be too greatly shocked to realize that although biographies have been written, and sectors of the field recorded (Deutsch's masterly *The Mentally Ill in America,* for example), there has been up to now no volume that portrays the origins and the full sweep of psychological medicine or medical psychology—or, to use what is relatively a *very* modern word, psychiatry.

As the reader follows the review of mental medicine through the ages, he is impressed with the centuries-long divorce of psychiatry from the rest of medicine. Mental diseases, for perhaps 90 per cent of the time that has elapsed since the days of early Greek medicine, have been considered to belong in the domain of theology, jurisprudence, or philosophy, more, at least, than in the realm of medicine. At such times as men of medicine—Hippocrates and Heraclitus, Galen, Weyer, Cornelius Agrippa, Paracelsus, and Felix Plater—took cognizance of the *terra incognita* of mental disorder and claimed it for their own, their hold proved all too tenuous, and they were displaced by the philosophers and the demonologists. It is, then, perhaps small wonder that psychiatry has had its difficulties in the present century in gaining recognition from medicine as something more than an unwanted stepchild!

Dr. Zilboorg's sweep of events is wide and free, yet he gives ample detail, quoting generously and giving an excellent sketch of the milieu in which each subject lived and worked. As for the readability and style of the book, one need say only that the author is one of the few really literary writers in the field of medicine to-day. His ability as a medical historian has previously been exhibited in his Noguchi lectures (*The Medical Man and the Witch in the Renaissance*) and his part in the *Four Treatises of Paracelsus.* He is Chairman of the Committee on the History of Psychiatry of the American Psychiatric Association, and is now engaged for that association in editing a monumental history of American psychiatry.

In the present volume, one meets many new names and misses very few old ones; the author undoubtedly had his reasons for omitting discussion of Timothy Bright's *Treatise of Melancholie* and Robert Burton's *Anatomy of Melancholy.* If the volume were designed

primarily as a textbook for students, one would ask for more references to original sources, but in a book intended not for the professional historian so much as for the interested physician (psychiatric or not) and for the intelligent general reader, such a demand would be carping indeed.

Dr. Zilboorg has made a highly significant contribution to the literature of psychiatry, of history, of biography, and of sociology, and has done it with a literary style that is distinguished. Two quotations will illustrate both his style and his ability to summarize a complicated subject succinctly. He summarizes the significance of Freud's discovery in these words:

> "The discovery was made on a neurotic patient, not a psychotic; it was made by means of a successful therapeutic test. This was the first time in the history of medical psychology that a therapeutic agent had led to the discovery of the cause of the illness while attacking or attempting to remove this cause. It was the first time in the history of psychopathology that the cause of illness, the symptoms generated by the cause, and the therapeutic agent revealing and removing the cause were combined in one succession of factors. It is doubtful whether the full meaning of this historical fact has as yet been properly appreciated. It was this combination that made clinical psychopathology a true medical discipline for the first time in the history of medicine's struggle for the incorporation of neuroses and psychoses into its field of scientific investigation and treatment."

His concluding paragraph runs as follows:

> "The whole course of the history of medical psychology is punctuated by the medical man's struggle to rise above the prejudices of all ages in order to identify himself with the psychological realities of his patients. Every time such an identification was achieved the medical man became a psychiatrist. The history of psychiatry is essentially the history of humanism. Every time humanism has diminished or degenerated into mere philanthropic sentimentality, psychiatry has entered a new ebb. Every time the spirit of humanism has arisen, a new contribution to psychiatry has been made."

Dr. George Henry contributes two scholarly and well-written chapters, one entitled *Organic Mental Diseases* and the other *Mental Hospitals*. They are worthy additions to the volume.

WINFRED OVERHOLSER.

Saint Elizabeths Hospital, Washington, D. C.

BORROWED CHILDREN. By Mrs. St. Loe Strachey. New York: The Commonwealth Fund, 1940. 145 p.

To any one who cares for children, this book will be of intense interest, and particularly so to those who helped plan for the arrival of English children in the United States in the summer of 1940. With

considerable insight, it gives glimpses of the humor, pathos, and tragedy involved in any such experience as a mass transplanting of children from their own homes to a new setting. It also gives evidences of lessons learned the hard way, as we, too, in this country learned the lessons the hard way from that pilgrimage of children in 1940.

As stated in the Foreword, wars, "whatever we may think of them, can teach something to those of us who are ready to learn.

"This war, owing to the danger from bombing from the air, has taught us—of all things—a great deal about children. Not only about the state of health and degree of cleanliness and 'civilization,' and so on, of the nation's children, but about how children—different types of children—will behave in unusual circumstances, and through that we find that we have learnt some fundamental truths about all children."

The first four chapters deal with the arrival of the children in the family homes graciously, though hastily, prepared for their billeting. To those who know child-placing, these pages are filled with material significant of the final outcome. For instance, in child-placing we have learned by experience that it is the type and age of child that the home really wants that will usually be best assimilated. Then out of such a mass experience comes this type of episode:

> "I had asked for and been promised a helper, no boys, and six girls of about 9 'plus'.
>
> "I ran downstairs. Two cars drew up. The doors opened on both sides and out of them tumbled eight little beings, none of them more than knee-high and half of them boys. . . . A tangle of gas masks, knapsacks, tiny great-coats, tumbled all over the floor of the hall. . . . The children were absurdly small. It turned out that the two eldest, both boys, were only eight, while a little elfin being with big eyes was found to be only five. It was a kindergarten that we were called on to undertake, a kindergarten of singularly calm and cheerful babies."

Household plans had to be adjusted to meet the children who arrived rather than the children who were expected, as was true in case after case and as could scarcely have been avoided in any such quickly developed plan.

All who watched the great evacuation of September, 1939, and the evacuation to America in the summer of 1940 have come to realize the dangers implicit in any such move. As the author points out, "the parents of city children must choose whether, not for a sudden, short crisis, but for a period of months, perhaps years, they will give their children mental *or* physical security; for they cannot give both." And she points out, too, that one question that puzzled the children, after the "singular calm" gave way to a more normal behavior and

they began to express themselves, was this: "Then why have we been evacuated? If it isn't safe for us, why is it safe for Mummie and Daddie?"

The whole book is intensely interesting. The first four chapters give a graphic picture of the undertaking. The last four present some of the experiences and detailed problems encountered. The general problems discernible in the book certainly call for careful consideration as we here in the United States face the responsibility of planning for children during a war period. We may find much that may be of infinite value in our present crisis, if we apply the lessons learned from this English experience and from the young Britishers who reached our shores.

SYBIL FOSTER.

New York Children's Aid Society.

PLAY FOR CONVALESCENT CHILDREN IN HOSPITALS AND THE HOME. By Anne Marie Smith. New York: A. S. Barnes and Company, 1941. 133 p.

A handbook for those who are doing recreational work among children in hospitals is greatly needed—one that would show the connection between certain fundamental emotional needs and children's play, especially those emotions that are implicit in the hazardous hospital situation. In Miss Smith's book, play is considered as a method of counteracting unpleasant experiences and as a substitute for unpleasant or useless activity, but it is not considered as a means of emotional expression. She says: "For the hospitalized child it is important that provision be made for nourishing and establishing his emotional development, since conditions of illness tend to exaggerate nervous tensions," and she goes on to describe various hospital situations that affect the child. But the psychological implications of play in such situations are not clearly set forth.

However, Miss Smith has written a very readable book. It is full of illustrative material from actual cases. The parts of it that are of most value are those that describe the set-up at Children's Memorial Hospital in Chicago. Whatever Miss Smith gives from her own experience as director of play is good, authentic material because she did a pioneering work in the field of play for children confined to hospitals.

The value of using traditional games is emphasized. Because these old games have been used for ages by people of all races, they are fundamentally satisfying to children. Children otherwise difficult to reach become interested in games at first contact. The old folk music of singing games is much loved by children, and singing became an important part of the play program. Nurses' and volun-

teers' classes were an integral part of the play department. The nurses learned not to be afraid to play. (It would be of value to know just how Miss Smith brought this about.) Through exhibits, parents were shown the right kind of toys to bring their children, and responded enthusiastically to playing games, with a nurse in charge, while waiting during visiting hours. Play before operations was used routinely. That this lessened the shock of operations was acknowledged by the surgical staff. The emotional content of pre-operative play is not mentioned.

The hospital had a large library, and a fine list of the books the children actually liked best is given. The children were guided in their reading, so that often good reading could be substituted for the corner-drugstore variety. However, Miss Smith disregards the fact that children in hospitals must have outlets for feelings of aggression and that one form of outlet is through identification in reading.

A chapter that should be of special interest to laymen is that on suggestions for gifts. This serves also as a classification of play materials that can be used in hospitals. One misses such items as soldiers or Indians (which are considered too exciting), hammer-and-nail sets, and real clay, which are used with success in some hospital situations. However, finger paints and dolls and furniture are included. The play material is carefully chosen for "safeness," as if this were a constant quality, when actually it varies with the supervision given. The last chapter, *Classification of Tested Forms of Play,* lists games that have been used with success. References are made to a few books that give directions for playing the games listed, but one wishes that the directions for playing the free games could have been given along with the games.

Altogether, the book contains a great deal of information and is a contribution to the negligible amount of material available in this field. One cannot but regret, however, that Miss Smith, with her long experience, did not give us a more complete handbook on play for convalescent children.

SUSAN S. RICHARDS.

Washington, D. C.

BORN THAT WAY. By Earl Carlson, M.D. New York: The John Day Company, 1941. 174 p.

This book, an autobiography, has all the refreshing charm of a simply related narrative and at the same time bears an important message. The author, as the title indicates—and as his mother used to say when he was small—was "born that way." He came into the world and spent his childhood days as a spastic cripple. It was

several years before he could move about in a position other than creeping, express himself intelligibly, or use his arms for tasks as simple as reaching for an apple. Personal determination, friendly encouragement, and medical aid lifted him out of his helplessness. He became a well-known specialist in the field of his own disorder, and the parents of thousands of spastic children have turned to him for advice and treatment.

There is no false modesty in this account of astounding achievement; Dr. Carlson is too much of a scientist to let that sort of sentiment stand in the way of a true recording of facts. He has the courage to tell of his own contribution to his unique rise. But he never forgets those who gave him material, therapeutic, and spiritual assistance. One finds here the beloved figures of Frederick Tilney and Stewart Paton. There are anecdotes about Dean Winternitz, of Yale, and stories that add a human touch to the renowned professional skill of Walter Dandy, Winthrop Phelps, and George Bennett, all of whom took a hand in the shaping of Dr. Carlson's career. Due credit is also given to the Stillman family, not only for their financial aid, but also for all the big and little things that they did for the ambitiously struggling cripple during his fight against seemingly insurmountable obstacles.

In reading the book, one sometimes almost forgets that this is a "true story." Although the style is simple and direct and free from literary embellishments, some of the characters compare favorably with the best that fiction has to offer. Dr. Carlson's mother, with her matter-of-fact common sense, his laboring father's grief and suicide, the friendship of young Stillman, the nurse who later became Mrs. Carlson—all leave indelible memories in the mind of the reader, who is enriched by his acquaintance with them.

Not every spastic child, it is true, will grow up to be another Dr. Carlson. But the fact that such developments have been possible in one case will squelch some of the glib talk about the blessings of euthanasia and should be heartening to parents of children who have neurologic, orthopedic, or other bodily impediments, who were born that way or who have become that way through no fault of man.

The book is an intensely fascinating human document. It should be in the hands of every physician, nurse, social worker, and teacher who has a chance to deal with spastic children. It is especially to be recommended to all parents of handicapped children.

It is to be hoped that in forthcoming reprints or new editions, the publisher will pay more attention to the external make-up of the book, which deserves better and more attractive paper and binding.

LEO KANNER.

The Johns Hopkins Hospital, Baltimore, Maryland.

FEEDING OUR OLD-FASHIONED CHILDREN. By C. Anderson Aldrich, M.D. and Mary M. Aldrich. New York: The Macmillan Company, 1941. 112 p.

This book carries the authors' thesis of "gratification" of the child's needs and wants into a most vital phase of the child's life. Since a large proportion of intra-family strife centers around mealtime, this volume based on the eating needs of the child is of real value to parents.

Aldrich, like a good many "modern" thinkers, recommends the methods used by our grandparents, rather than those employed by our parents, in the handling of our children to-day. That such ideas are not mere heresy is amply demonstrated by present-day research findings. Aldrich emphasizes consideration of the child as a whole in our understanding of feeding. With very little technical terminology, he discusses the problem of normal eating from the point of view of hunger and appetite. Appetite, Aldrich says, is the key to enthusiastic eating and must be cultivated by the parents. By this he does not mean controlled or regulated. He maintains that "appetite is a basic mechanism, capable of controlling our food intake" and a "selective mechanism for eating which may be relied upon." Dr. Clara Davis' researches on infant feeding are reported in this connection.

The authors stress the tie-up between the emotional life of the child and his appetite. The rôle of the parents in feeding thus becomes one of satisfying the emotional as well as the appetite needs of the child. This means more than merely supplying the necessary food. It involves an adjustment of the parents to the child's natural rhythms, a responsiveness to his need for love and comforting. The task is in large measure one of imposing no restrictions on the free development of eating. The import of this is seen in this typical statement by the authors: "People became so busy doing things to children for their own good that the children themselves were crowded out of the project."

The authors repeatedly urge that the infant's feeding schedule be established according to his individual rhythm. The question of food intake is also treated. Aldrich cautions against overfeeding and states that "a child should not be given more than the amount of food that he will finish eagerly." This is particularly important in the handling of an established case of anorexia. Signs of increased desire to eat, rather than an increase in the amount eaten, should be the goal. In discussing the treatment of such cases, the Aldriches also recommend a change of attitude in the adults, an end to coercion and the forcing of food, a thorough physical examination, temporary changes in the diet, and, with older children, an opportunity to let them work it out for themselves.

The book is written in a simple and engaging style. Basic principles of mental hygiene are brought to the fore in the discussion of the emotional life of the child and in the suggestion as to the best setting for feeding.

RUTH J. KRAINES.

Chicago, Illinois.

PERSONAL PROBLEMS OF EVERYDAY LIFE. By Lee Edward Travis and Dorothy Walter Baruch. New York: D. Appleton-Century Company, 1941. 421 p.

This is a "psychopathology of everyday life" that is simply discussed, with emphasis on the practical implications. The authors have succeeded rather well in proving their contention that the fundamental concepts of mental hygiene can be expressed in simple language.

How effective an intellectual approach—that is, the reading of such a book as this or of any book—can be in the prevention and treatment of mental ills, is another matter, about which one may express skepticism. Perhaps the question is irrevelant for our present consideration, since we are concerned not with the general value of popularized writings on the subject, but with an evaluation of the adequacy with which this particular book covers the area in which an intellectual approach may be effective. That the book must be classified as a popular treatment of the subject seems apparent from the method in which the material is presented, and the label "Students' Edition" can hardly change its status. We feel that its circulation will not be limited to the college-student group. It certainly merits a wider reading.

The necessity for an intellectual attack on the problems of mental hygiene cannot be denied. First of all, it is at present the only method by which it is possible to reach many people at all. All workers in the psychiatric field are, I believe, concerned with the fact that their work only scratches the surface of the great bulk of problems of maladjustment represented in the general population. Again, there is the very great need for this method as a preliminary step in preparing the way for further mental-hygiene work from other directions.

It is axiomatic that people must, first of all, know about sound mental-hygiene concepts if there is to be any appreciable diminution of human misery. From the point of view of future generations, the significance of such books as this should surely be very great. Their value in remedying present adult mental ills, in breaking up already well-established pernicious patterns and unhealthy attitudes, undoubt-

edly cannot be so great, but even a small entering wedge helps, and because of the nature of human relationships, the beneficial effects rapidly multiply themselves, as the authors clearly demonstrate. One envisions sound mental-hygiene concepts displacing unhealthy concepts in our culture. One already sees some slight progress in this direction.

There is in this book nothing that should be harmful. This should be an imperative prerequisite for all writing that is likely to be widely read by the general population. Workers in the field of mental hygiene are acutely aware of the injurious distortions that material may undergo in the mind of the uninitiated person—distortions that are, of course, tied up with his own particular problems. This very fact, however, necessarily places a grave responsibility upon a writer. The present volume has the merit, along with its simplicity, of obviating so far as possible the opportunities for such distortions.

The criteria for evaluating writing in the field of mental hygiene for nonprofessional persons may reasonably be summed up in the following questions: 1. Is the presentation in such form that it is readily comprehensible by the group for which it is intended? 2. Is the nature of the problem such that a popularized treatment of it can be effective? 3. Is care exercised to see that there are as few opportunities as possible for unintentional distortion, with resulting harm to those whom we are trying to help? 4. Are preventive and therapeutic procedures presented in such a way that they are seen as necessary, desirable, and entirely acceptable measures? 5. Is information given as to where one should go for competent advice when in need of help in one's personal adjustment?

This book, we feel, meets these standards in a very satisfactory way.

EDWARD S. KIP.

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THE ADOLESCENT PERSONALITY. By Peter Blos. New York: D. Appleton-Century Company, 1941. 517 p.

This book is one of the valuable derivatives of the "Study of Adolescence" conducted by the Commission on Secondary School Education, which was set up in 1932 by the Progressive Education Association.

The volume under review consists of five parts. Part I deals briefly with certain fundamental concepts of personality—such as the purposiveness of behavior, the continuity of the developmental process, and the multiplicity of causation in personality development—and discusses the validity of the case study as one approach

to an understanding of personality structure. Part II presents in detail the case histories of two adolescents, with interpretative material on the dynamics of their behavior. Part III concerns itself with theoretical material on the nature of adolescence, its sources of strain and conflict, and the influence of early experiences upon adolescent development. Part IV presents two additional case histories in detail, with some discussion of the interviewing process through which understanding of these adolescents was in the main secured. Part V deals briefly with the implications, for school programs and teacher attitude and responsibility, of this understanding of adolescence.

Dr. Blos has made a significant contribution to educators in organizing and presenting such a complete and well-rounded picture of what is involved in being an adolescent. His references at the end of each section testify to his own wide reading, and the material gives evidence of his integration of the points of view of writers concerned with the various aspects of adolescent development.

The case material, while graphic, seems at points so detailed as to verge on the repetitious and tiring, and this is true to some extent, too, of the theoretical section on adolescent development. However, for readers who are totally unfamiliar with the field under discussion, this detail may be helpful. I assume that some part of the study will deal much more fully than has been possible in this book with the implications as to changes in the secondary-school curriculum and with a clarification of the purpose of the secondary school and of the professional preparation, function, and responsibility of teachers and other school personnel within it.

Dr. Blos sees education generally as (p. 491) "an instrument to foster the normal development of the whole child." Just as the old-time school was too narrow in its conception of its function, may there not be a danger that some leaders in progressive education will become so diffuse and general in their aims, and so hazy as to what should constitute the professional preparation and methods of the personnel seeking to accomplish all or some of those aims, that considerable confusion may result?

The four case histories presented in the book were selected from 600, collected as part of a study of adolescence. Much valuable material was undoubtedly secured. One cannot help wondering, however, what happened to some of the adolescents in the course of being "studied." There is no statement as to the specific professional preparation of the interviewers, and one feels that their task was an extremely hazardous one. They were not associated with any social agency set up to give, under known conditions, specific social services. Neither, I gather, were they qualified as

therapists, with all that this implies in the way of professional preparation and discipline. Nor could the students be entirely clear, as the interviews progressed, as to why they were being interviewed and what the purpose of the interviewer was in relation to them.

In the case of the first two adolescents whose histories were presented, we are told (p. 23) that "no guidance responsibility was assumed by the worker who conducted the interviews. Indeed, he intentionally avoided any such responsibility." One questions whether one can avoid such responsibility when regular interviews are held with an adolescent on a subject of such emotional moment as his feelings about himself and his family. In the case of the second two adolescents, apparently some guidance responsibility was assumed, but what kind of guidance, whether counseling or therapy, is not clear.

The worker whose interviews with one of these adolescents were analyzed, from the point of view of the procedure used in helping the adolescent through the interviews, is described (p. 425) as follows: "an outgoing, natural, and lively person who has had an extremely wide range of experiences and is aware of the influences they exert on his reactions. [By his own acknowledgment, he was *not* aware of the influence they exerted on his relationship with the adolescent whose case history is the last one presented.] He is attentive and alert about details, inventive and intuitive in keeping up the flow of conversation during an interview." There is no reference to his professional preparation either for practicing therapy or for giving guidance or counseling service. Dr. Blos refers to the necessity of a "specific kind of equipment," for guidance workers who are dealing with personality problems, but he nowhere discusses what that equipment should be or whether the interviewers employed in this study had it.

That Dr. Blos has made a contribution through this presentation of detailed case material cannot be gainsaid. It was a presentation much needed by the educational group to whom it is addressed. One hopes that the method of securing data will not lead to irresponsible "dabbling" in therapy, or in counseling or guidance, by those not professionally prepared to practice. Dr. Blos himself sounds a warning against this. He speaks of the advisability of referring children who need individualized help to the appropriate community resource and states (p. 505): "It is neither possible nor necessary for the teacher to go into the details of each student's life history in order to guide his students competently. . . . Teachers usually know infinitely more about their students than they are able to utilize." The next great task is to reconsider what the professional preparation of teachers and guidance workers shall be, as

well as to provide teachers and guidance workers of adequate and appropriate professional preparation with specific procedures for using, in the responsible practice of their own professions, the understanding to which Dr. Blos has so generously contributed.

RUTH SMALLEY.

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CREATIVE GROUP WORK ON THE CAMPUS. By Louise Price. New York: Teachers College, Columbia University, 1941. 437 p.

This book is an investigation—not a survey—of the development of certain aspects of student life at Stevens College in Missouri and at Stanford University in California, the author having served on the faculty of both institutions.

The first two chapters deal with the background of the study and include historical data. They are followed by a chapter on the newer aspects of social psychology, as represented in the work of Dewey, Wertheimer, Köhler, Koffka, Follett, Gordon Alport, Lewin, Moreno, and others. The text is, after all, a study of the development of a process, and the chapters that follow are of much greater interest to the reviewer, but the early part of the book is important from the point of view of orientation.

The history of Stevens College is divided into five periods. During the first (1913–18), ideas and policies for the future were incubated; during the second (1919–24), there was a complete reorganization of the student-activities program, based on systematic study and experimentation; the third period (1925–30) saw the development of the guidance program; the fourth (1931–34) does not stand out for any particular reason; the fifth (1934–40) was characterized by the development of the counseling program and the (so-called) clinics, under the supervision of "a staff of expert clinicians," dealing with consumer problems, growth, English usage, vocational guidance, health, personal grooming, posture, reading, study, problems in philosophy and religion, and speech.

The reasons for retaining the sorority system are candidly stated: (1) its positive values had not yet been explored; (2) junior-college transfers frequently had difficulty in pledging to a sorority when they went to another school; (3) "membership involved social status for the family and often seemed pathetically important"; (4) students found "security" in "a group of friends into which they had been chosen"; (5) "off-campus" living was a convenience at a time when dormitories were crowded; and (6) membership encouraged return for a second year.

A social-achievement questionnaire reveals much pertinent data.

The following three items lifted from it will be of particular interest to the mental hygienist: Many (48 per cent) of the students had trouble in getting along with their roommates or suite mates; others (28 per cent) suffered from self-consciousness; a smaller number (18 per cent) suffered from feelings of inferiority. The method evolved by faculty members for handling these and many other personal problems of the students is discussed.

The section on student life at Stanford defines the origin and growth of certain important traditions: (1) the family or "clan" feeling; (2) the democratic tradition; (3) emphasis on the scientific method; (4) freedom in student expression (the wearing of dirty corduroy trousers, or "cords," and open-throated shirts, old sweaters . . . absence of hat and necktie became a stereotype for men's behavior; it included going unshaved and even unbathed); and (5) extension of the curriculum to include social problems. The chapter entitled *The Evolution of a System of Social Control Which Tempers Student Freedom with Social Responsibility* is one of the best in the book. The work of the Union Club is adequately outlined, and the chapter on student government should be read by every school administrator whenever he feels that all of the new student problems, as well as some of the old ones in disguise, have suddenly turned up at his office.

The objectives of creative group work on the campus are defined in the last chapter under the following headings: *Social Participation, Personality and Education Achievement, Contributions of Individuals, Stimulation of Interests, Rich Environment, Personal Responsibility, Therapy Through Group Experience, Continuous Group Growth, Freedom to Make Plans,* and *Socially Responsible Leadership.* The bibliography is adequate, and an appendix contains the social-achievement questionnaire used at Stevens College and panel discussions as carried out at Stanford.

This is an interesting book and it will undoubtedly be read widely in our more progressive colleges and universities. This reviewer was impressed by the tremendous number of mental-hygiene problems encountered. These personality problems, or their essential ingredients, existed before the student went to college, and one wonders what happens to the student who does not respond satisfactorily to a group experience. The major task of modern education in America, as stated by the author in the opening sentence of the book, is "to individualize education and to socialize the individuals whom it educates." Is this to be done en masse by the faculty, with the assistance of counseling and guidance personnel, assuming, of course, a school setting conducive to growth and development? Some comments on the professional training of the guidance counselor for

a specific task, and a clear statement as to how he could best collaborate and coöperate with allied professional fields, would have been helpful. This was not the purpose of this book, but a clarification of these points would have done much to enhance its value.

MILTON E. KIRKPATRICK.

The National Committee for Mental Hygiene.

SOCIAL CASE RECORDS FROM PSYCHIATRIC CLINICS, WITH DISCUSSION NOTES. By Charlotte Towle. Chicago: The University of Chicago Press, 1941. 455 p.

In spite of the thousands of varied and instructive case records available in the files of psychiatric and child-guidance clinics, it is only with the greatest difficulty that it has been possible to utilize any of these for wider educational purposes in anything approximating their original form. For this reason, the book under discussion is of great value, because it makes widely available in printed form the social case records of twelve patients seen in the following psychiatric services in Chicago: the Institute for Juvenile Research, the Department of Neuropsychiatry of Michael Reese Hospital, and the Department of Psychiatry, University of Chicago Clinics.

The book was prepared primarily as a basis for study and discussion in the author's own case-work classes at the School of Social Service Administration of the University of Chicago, and "the interpretative thinking which took place in staff conferences and between supervisors and workers has been largely deleted," in order to stimulate the student's own analysis of implications in the material presented. The cases were selected because the quality of case-work was not beyond that which the student might be expected to achieve, because they offered material on a variety of diagnostic and treatment problems suitable for discussion purposes, and because they represented "sound method on the whole, with some resultant therapeutic gains." The predominant focus in the records is "upon the utilization of case-work methods in relation to the emotional needs of the patient as determined by the social, economic, biological, and psychological forces within his life-experience."

An admirable coöperation between medical and psychiatric services is indicated by six records of patients referred for psychiatric study and treatment after no adequate organic basis had been discovered for their physical symptoms and complaints. This unusually close integration of medicine and psychiatry is also emphasized in two additional cases—an adolescent boy with a record of delinquency, who was suffering from osteomyelitis, and a five-year-old girl with a cardiac condition, who very early developed a peculiar habit of

chewing and eating a variety of unsuitable articles. The remaining records concern a self-willed, unruly eleven-year-old boy of superior intelligence, who had become estranged from his mother, a mentally defective four-year-old boy, and two young married women distraught with anxiety and fears.

In a brief introduction, Miss Towle analyzes the underlying philosophy, the general goals of classroom discussion, and the manner in which case records may be used for teaching purposes. A more detailed presentation of the discussion topics involved in each individual situation is appended at the end of each case record, together with a pertinent bibliography of articles and books relating to the various mental-health and social-work problems presented.

This book will not only be welcomed and widely used by teachers of case-work in schools of social work, because the presentation has been so carefully worked out for teaching and discussion purposes; it will without doubt be of great value to individual social workers, as well as to supervisors and case-workers in social agencies and institutions who are interested in staff development programs. Although the psychiatric diagnoses and the psychiatric and case-work treatment goals sometimes seem rather hazy and lacking in the clarity and precision that it is hoped will at some future time be more adequately achieved through further scientific developments, the effectiveness of this approach to human problems is quite evident; improvements in personal adjustments were attained.

It is to be hoped that additional volumes of this kind will be forthcoming from time to time and will be fully utilized for educational purposes in the training programs of various professional fields.

CLARA BASSETT.

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MENTAL DISEASE AND SOCIAL WELFACE. By Horatio M. Pollock. Utica, New York: State Hospitals Press, 1941. 237 p.

This volume is an important and welcome addition to the growing literature that undertakes to give us a clearer picture of mental disease in its social relations. It constitutes a valiant attempt to furnish the statistical bases upon which such fundamental questions as these might be authoritatively answered: What is the social significance of mental disease? What are the average person's chances at any age of becoming a patient in a mental hospital? What are the chances of recovery of a patient in a mental hospital? What will be the future of mental disease? Is mental disease inherited? To what extent is mental disease due to alcohol? What does mental

disease cost the state and the nation? What are the results of insulin and metrazol treatment?

A series of sixteen previously published articles constitutes the book. In developing statistical programs to cover the entire mental-hygiene field, in which he is an outstanding pioneer, Dr. Pollock was deeply impressed by the unfavorable influence exerted on society by mental disorders and felt "that institutional care of the mentally ill was a rapidly growing problem and that sooner or later it would have to be dealt with in a large way."

It must be extremely disappointing to the author that his own figures, compiled so painstakingly and assiduously over a period of years, do not bear out his earlier optimism that the increase in the mental-hospital population might be checked and that mental illness would eventually be lessened. He observes that mental patients in New York State to-day exceed all other hospital patients combined by over 50 per cent, and are more than three times as numerous as the prison and jail populations.

Perhaps one of the most important statistical contributions embodied in this volume are the figures compiled in collaboration with Dr. Benjamin Malzberg on the expectation of mental disease. They contain the oft-quoted figures that, in 1920, the expectation of mental disease for persons born in New York State was 4.5 per cent. Among males the expectation was 4.7 per cent and among females, 4.3. Expressed as a ratio, the expectation of mental disease was 1 to 22 for both sexes combined. In other words, 1 in 22 of the persons born in the state may be expected to develop serious mental disease and undergo treatment therefor in a mental hospital at some period of life.

Accompanying these figures is Dr. Pollock's significant comment: "When we consider that these data relating to expectation include only hospital cases of mental disease and that mild cases of mental disease that do not reach mental hospitals are probably as numerous as hospital cases, it becomes reasonably certain that at least one-tenth of the population is now or will be afflicted by mental disease."

If space allowed, it would be very profitable to quote at length from this book, which illumines such a variety of subjects of distinct value to all those interested in the mental-hygiene movement and its relation to the general welfare of society.

In closing this all too brief review of a very thought-provoking study, it may be well worth while to quote the author's own views on the future of mental disease, which, while disquieting on the whole, also strike a more optimistic note: "Mental disease throughout

the world at present (1941) is an increasing rather than a decreasing social problem. The proportion of the population suffering from mental disease is constantly getting larger, and economic losses due to mental disease are continually mounting. The situation, however, is not without hope. Much has been learned concerning the causes and nature of the various abnormal mental conditions, and progress is being made in their treatment and prevention. If some great research worker like Pasteur should discover means of preventing arteriosclerosis, dementia praecox, and manic-depressive psychoses, the whole aspect of the problem would be changed. If important discoveries in this field are not made, mental disease, in the not distant future, will supersede physical disease as the paramount health problem. We can take courage from what has been accomplished in the field of physical disease, and we may confidently expect that by multiplying means of research and by diligently disseminating the recently acquired knowledge of mental hygiene, the burden of mental disease will be lessened for future generations."

EMIL FRANKEL.

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A STUDY OF A GROUP OF CHILDREN OF EXCEPTIONALLY HIGH INTELLIGENCE QUOTIENT IN SITUATIONS PARTAKING OF THE NATURE OF SUGGESTION. By Rachel McKnight Simmons. (Columbia University Contributions to Education, No. 799.) New York: Teachers College, 1940. 112 p.

An equally appropriate title for this volume might be, "A Study of a Group of Children of *Low* Intelligence Quotient in Situations Partaking of the Nature of Suggestion." That is, Dr. Simmons compared children of high intelligence, their median I.Q. being 142, not with a normal group, but with children "known to be low in intelligence," their median I.Q. being 87. On both objective tests and ratings, the gifted are less suggestible than the dull. It is carefully explained that these findings are limited to the particular groups and tests employed! Exactly.

FRANK K. SHUTTLEWORTH.

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THE NURSING COUPLE. By Merell P. Middlemore, M.D. London: Hamish Hamilton Medical Books, 1941. 195 p.

This is a most unusual book on a topic that has received the scantiest attention from obstetricians, pediatricians, and psychia-

trists. It has to do with the reactions of baby and mother as a "nursing couple" in the first days after birth, through the period in which the baby learns to suck at the breast, with an accurate, objective description of the varieties of infant behavior and of maternal behavior in the whole experience of nursing. The author observed approximately fifty couples, and these observations led to a descriptive classification of babies in this situation as satisfied sucklings and unsatisfied sucklings. The former were further subdivided into active sucklings and sleepy sucklings, and the latter into excited, ineffective sucklings and inert sucklings. The inert sucklings were again subdivided into sleepy babies and simply inert and irritably inert sucklings.

The book is important as representing a first step in the observation of a most important period in a patient's life, because there are numerous reasons for believing that the emotional reactions engendered in the process of learning to nurse at the breast may be of paramount importance in determining future traits of unlimited potentialities. Dr. Middlemore was not able to arrive at any definite conclusions as to the factors at work in the production of these various reactions to suckling on the part of the baby, but the book is full of very keen observations on the behavioristic components of the phenomenon, from the standpoint both of the baby and of the mother. The two chapters toward the end of the book on the mother's reaction to nursing as an experience and on the significance of the nurse and the physician in this phenomenon are full of such observations and of sound advice.

The book has a foreword by Edward Glover, who calls attention to the fact that the author was a qualified psychoanalyst, and the book is important rather for its psychological than for its pediatric implications. It is a book that I feel should be read by every one who has anything to do with babies—parents, doctors, nurses, psychologists—as offering a starting point for further fruitful examinations of this interesting phenomenon.

Dr. Middlemore died prematurely. The manuscript was edited by friends after her death, and the book has had practically no distribution because a large part of the stock was destroyed in the London raids. It is a book that might profitably be reprinted by arrangement with some publisher in this country, where it no doubt would have the wide distribution it merits.

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NOTES AND COMMENTS

Compiled by

PAUL O. KOMORA

The National Committee for Mental Hygiene

THE NATIONAL COMMITTEE FOR MENTAL HYGIENE PUTS ITS SHOULDER TO THE WHEEL IN THE WAR EFFORT

Deeply sensible of its responsibilities in the national emergency, The National Committee for Mental Hygiene has for some time gathered its strength and mobilized its modest resources for this day of need. The Thirty-first Annual Meeting of its members, in 1940, and the Thirty-second Annual Meeting, in the following year, were devoted to a discussion of the country's defense program, and early in 1941 a War Work Committee was formed in anticipation of mental-health defense needs. The National Committee promptly put its services and experience at the disposal of governmental and other defense agencies and has ever since applied itself vigorously to the war effort.

This effort has a major claim on the time and attention of the committee's staff, and in collaboration with our associated state and local societies for mental hygiene, we have engaged in many and diverse activities of an emergency nature. A brief description of some of these activities follows. They will be more fully discussed in the organization's annual report for 1941, to be published shortly.

In the fall of 1941, the National Committee obtained from state societies accounts of war work then in progress. To these were added the list of mental-health needs that had come to our attention from other sources, and subsequently we drew up a set of suggestions for state societies, to guide them in developing their programs. On February 9, 1942, executives of state societies met in Detroit with representatives of the Surgeon General's Office and the local induction board, for a discussion of the mental-hygiene problems of the emergency. Most pressing among these problems are those connected with Selective Service.

After this meeting, three sets of directions were formulated by persons who have done outstanding work in this field, (1) in clearing state records concerning selectees; (2) in clearing local records; and (3) in making individual investigations for Selective Service boards. These directions will shortly be transmitted to state societies, which will be encouraged to work on them at once. A follow-up

meeting of state-society executives is being planned for May 10-16 at the National Conference of Social Work, in New Orleans, and again at the annual meeting of the American Psychiatric Association in Boston, May 18-22.

Early in 1941, the National Committee conducted four experiments in Selective Service designed to bring to attention public records and knowledge of registrants at four different stages of selection and in four different types of community. The procedure worked out in these experiments was shown to be both productive and practical on the basis of volunteer assistance. In Hartford, one of the four communities, the experiment immediately expanded into a routine clearance of all Class 1A men through the state files for mental disease, police records, and so on. An effort was also made to apply the same procedure to the examination at induction.

Later in the year, in coöperation with the New York State Department of Mental Hygiene and the New York State and City Committees on Mental Hygiene, we presented a proposal for including investigators' reports in the induction examinations. This met with full approval, and, subsequently, plans were worked out for the utilization of volunteer investigators in New York City in the hope that similar procedures will be adopted throughout the state and in other states.

A study has also been made of a group of army psychiatric casualties, mostly dementia-praecox cases. The purpose of this study was to discover better methods of history-taking, and, what is even more important, to answer in each case the question: "What might have been done to prevent the entrance of this man into the army or to forestall his breakdown?" Out of these investigations definite leads appear, which, if followed, will forestall some cases of breakdown, but they show that, on the whole, selection has been quite good within the framework of the present Selective Service set-up, and much better than has been the case with enlistments. They also show that if the mentally unfit are to be discovered in time, many of the cases must be identified by early in-service diagnosis. Early in-service diagnosis is possible by special effort at several points: by the Red Cross, or, at the army-life level, by morale officers, by company officers, chaplains and dispensary workers, and by the various private organizations that serve the soldier outside the cantonment.

Since U.S.O. agencies meet the soldier on an unauthoritative basis when he is outside the regimentation of the army and is faced with the necessity of making his own decisions, they are in a favorable position to sense problems and guide the soldier to help. A project has, therefore, been designed to develop this counseling function in

one cantonment area for a nine months' experiment, with the possibility of greatly augmenting the services of these agencies, already so much appreciated by the soldier.

The Red Cross has assumed certain responsilibities of a mental-hygiene nature in relation to the selection of navy personnel, in the rehabilitation of neuropsychiatric casualties, and in other activities. Because of these functions, it has called on the National Committee for advisory service, and has formed a mental-hygiene advisory committee, on which we are represented. Through this committee, standards of personnel have been formulated. We are also assisting the Red Cross in securing a psychiatric-social-work staff and in recruiting persons to fill the vacancies thereby created. The Home Service of the Red Cross offers unparalleled opportunities for mental-hygiene education and service throughout the country. Some of these opportunities are now being studied in anticipation of a program of action.

In the field of citizen morale, the National Committee is assisting the United States Children's Bureau in planning and conducting radio programs. "Children in Wartime" was the theme of a weekly broadcast given during the past winter over a national hook-up, in which mental-health problems received special consideration; and, on March 30, another series of weekly broadcasts on the same theme was begun by the Children's Bureau, in which our medical director is participating. Assistance was given the Bureau also in organizing a mental-hygiene advisory committee. This committee has prepared pamphlet material to guide parents in wartime. It has also been called upon to review critically certain publicity material on morale put out by others. As a next step in this field, the National Committee is conducting interviews with persons in the New York area who are so situated as to encounter disturbances of morale—teachers, social workers, psychiatrists, ministers, and others. Anecdotal material is thus being gathered showing not only the forms and causes of disturbed morale, but the changes that take place in morale from time to time. In addition, child-guidance clinics throughout the country are reporting evidences of disturbed morale that come to their attention, and this material is being studied in anticipation of a report on the subject.

Orthopsychiatrists Discuss Behavior Reactions to War

How parents and children are reacting to changing conditions in the American scene under the impact of war was a central subject for discussion at the Nineteenth Annual Meeting of the American Orthopsychiatric Association, held in Detroit February 19–21, under the presidency of Dr. J. Kasanin of San Francisco. Reporting on

the behavior of children during the first blackouts on the West Coast, as observed by psychiatrists at his clinic at Mount Zion Hospital, Dr. Kasanin told the conference that the contagion of anxiety from their parents or other adults was the most noteworthy factor in children's reactions. "In every situation, when the parent or adult in charge of a child showed evidences of fear or panic," he said, "the child reacted in a similar manner and usually to an exaggerated degree." It was also noted that the more stable children showed a greater propensity to return to a state of emotional equilibrium after the excitement, and in a shorter time, than did the unstable ones. In other words, when there was already an anxiety state present, the reactions were more pronounced.

From Dr. Harvie De J. Coghill, of the Children's Memorial Clinic, Richmond, Va., came the interesting observation that children in that vicinity showed evidences of fear generated by war news as early as a year ago. It was found that children who listened to repeated radio broadcasts often became extremely disturbed. Sometimes they turned pale and left the room; sometimes they were not able to eat or to retain their food. A few talked much about the war, and many had fears that were not expressed verbally, but by night terrors or other symptoms. Dr. Coghill, too, emphasized the point that "an atmosphere of unrest and apprehension generated by nervous parents in the home probably lay at the basis of the child's difficulties." A marked change, however, has been observed since Pearl Harbor. "Our children seem to be less anxious," said Dr. Coghill. "Part of their change of attitude may be accounted for by the many convoys passing through Richmond and other evidences of our preparedness, plus change in parental attitudes, plus the reassurance received from clinic contacts."

The experience of England also has shown that children stand up to wartime tensions about as well as their parents do, according to Dr. Elisabeth R. Geleerd of the Southard School, Topeka, Kansas, who was in London during the first year of the war and made first-hand psychiatric observations of the special problems of children under war conditions. She described the reactions of families who had escaped to England during the battle of the Lowlands and France. All the children had been through air raids, had been bombed and machine-gunned on the roads and at sea, yet she reported: "None showed symptoms of anxiety or shock and none had nightmares." Her explanation was that the children had not been separated from their parents and the parents had not lost their heads.

Similar findings were reported by Dr. Grete L. Bibring, a member of the Psychoanalytic Institute of Vienna, who accompanied Freud and a group of analysts to London after the Nazi invasion in 1938

and continued her studies in England during the pre-war, war, and *Blitzkrieg* periods. "It has been my observation," said Dr. Bibring, "that the psychological state of the mother or of the adult living with the child almost entirely determines the psychological reaction of the child to most of the war experience. For example, children evacuated to safety zones with mothers who were suffering from fears and anxiety frequently showed more nervous symptoms than those left in bombing zones with calm and well-balanced mothers who were capable of conveying their confidence to the children."

Various aspects of psychiatric organization for war were studied at a special round table attended by representatives of the army and navy and the Selective Service. Emphasis was given to the importance of psychiatric aid on the industrial as well as the military front as a factor in the conservation of manpower.

The following officers of the association were elected to serve until the next annual meeting: President, Dr. Henry C. Schumacher, of Cleveland; president-elect, Dr. George H. Preston, of Baltimore; vice-president, Simon H. Tulchin, of New York; secretary, Dr. Norvelle C. LaMar, of New York; treasurer, Dr. Milton E. Kirkpatrick, of New York.

"The Four Horsemen of Morale Destruction"

The following "Notes on Civilian Morale" have been circulated among members of the American Psychiatric Association by its Committee on Public Education, with a request for their widespread use "on public occasions and in private relationships." They are of such cogency and timeliness that we reproduce them in full:

> "Overanxiety may cause civilian panic in war emergencies and may be brought about (1) purposefully by the enemy, or (2) may be caused by inadequacies in the individual.
>
> "*Purposefully induced anxiety is a part of the technique of modern propaganda warfare.*
>
> "1. *Threats.* Following attack by bombardment or air raids, the enemy blares, 'This is only the beginning,' or, 'Only a fraction of our force was used,' or, 'The full brunt has not yet been felt.' An understanding of this 'threat of things to come' as a part of propaganda technique is the best antidote to this form of mental sabotage.
>
> "2. *Rumors.* These bear chiefly on impending disasters or 'great losses of our troops' or, 'worse than the authorities have stated' or, 'sabotage—there are saboteurs all around us,' or, plaints about 'our inadequate leadership.' Antidote to this is *stop, look, and think.* Ask where the rumor came from; challenge it instead of accepting the statement. Do not help to spread it—more, tell your informant you're not accepting it; suggest that he's helping the enemy by repeating the story, without official confirmation. In short, tell him to 'pipe down.'

"The technique of 'threats and rumors' was used successfully in France. If you know it, then it becomes ineffective. *Some anxiety states are the result of personal inadequacy.*

"3. *Fatigue.* Those who suffer from fatigue are pessimistic and gloomy. This is particularly important in executives who may transmit their gloom to others. Undue fatigue, particularly among those engaged in special defense duties, should be avoided.

"4. *Malnutrition.* Poor physical health and undernourishment make people gloomy, pessimistic, and fertile soil for planting seeds of panic. Improved nutrition is a pertinent public-health problem at this time for the improvement of morale. Well-nourished people are optimistic and are less apt to 'crack' in an emergency.

"*The four horsemen of morale destruction are: threats—rumor—fatigue —malnutrition.*

"Because of their key positions, air-raid wardens have probably been chosen with a consideration of their stability. Overanxious, 'edgy' people, peevish people, people who are always 'in a hurry,' have probably been refused because their overanxiety can be contagious and might result in panic in others.

"These 'key' men in civilian defense are probably resourceful, quick and decisive, capable of reëstablishing the usual routine as quickly as possible. Experience has demonstrated that *mental casualties result not so much from threat of bodily harm as from disruption of the normal living processes.*

"The best antidote to panic is harnessing the usual tendency of people to get together in groups in emergencies by directing their energies in positive, constructive ways through clearly defined duties.

"'*Safety first*' *must of necessity give way to service first.*"

Conservation of Scholarly Journals

The American Library Association appointed this last year a Committee on Aid to Libraries in War Areas, headed by John R. Russell, Librarian of the University of Rochester. The committee is faced with numerous serious problems and hopes that American scholars and scientists will be of aid in the solution of one of these problems.

One of the most difficult tasks in library reconstruction after the first World War was that of completing foreign institutional sets of American scholarly, scientific, and technical periodicals. The attempt to avoid a repetition of that situation is now the concern of the committee.

Many sets of journals will be broken by the financial inability of the institutions to renew subscriptions. As far as possible they will be completed from a stock of periodicals now being purchased

by the committee. Many more sets will have been broken through mail difficulties and loss of shipments, while still others will have disappeared in the destruction of libraries. The size of the eventual demand is impossible to estimate, but requests received by the committee already give evidence that it will be enormous.

With an imminent paper shortage, attempts are being made to collect old periodicals for pulp. Fearing this possible cause of reduction in the already limited supply of scholarly and scientific journals, the committee hopes to enlist the coöperation of subscribers to this journal in preventing the sacrifice of this type of material to the pulp demand. It is scarcely necessary to mention the appreciation of foreign institutions and scholars for this activity.

Questions concerning the project, or concerning the value of particular periodicals to the project, should be directed to Wayne M. Hartwell, Executive Assistant to the Committee on Aid to Libraries in War Areas, Rush Rhees Library, University of Rochester, Rochester, New York.

Red Cross Psychiatric Social Workers to Be Assigned to Naval and Marine Corps Training Stations and Army Posts

The American Red Cross has sent out a call for trained and experienced psychiatric social workers to serve the armed forces. It is estimated that some sixty psychiatric workers will be needed during the next three months. These workers will be employed in the psychiatric wards of general hospitals of the army, in psychiatric units attached to naval or Marine Corps training stations, and in medical units with overseas forces. The function of the Red Cross psychiatric social worker in naval stations is described as follows: to assist the psychiatric unit by interviewing patients in order to supplement the psychiatrist's information and diagnosis, and by obtaining histories through Red Cross Chapters and other sources regarding the recruit's early environment, employment, institutional care (if any), and general behavior prior to enlistment. When a man is diagnosed as unsuited for military duty, the social worker refers the recommendations of the psychiatrist to the home Red Cross Chapter, and this necessitates interpretative service to the man's family, friends, and future employers.

The decision to use Red Cross psychiatric social workers in the military services followed the setting up of a psychiatric unit at the Newport Naval Training Station. In December, 1940, the Surgeon General of the Navy requested the Red Cross to assign a psychiatric social worker to the unit, the worker to be attached to the adjacent naval hospital and to report daily to the psychiatrist. This plan of

organization was necessary as women were not authorized members of the staff of naval training stations. The value of psychiatric social work in this military setting having been demonstrated, the Surgeon General arranged with the Office of Naval Operations, the Bureau of Navigation, and the Marine Corps Headquarters, to permit a Red Cross social worker to be assigned directly to the psychiatric unit functioning with a navy or Marine Corps training activity, and requested the appointment of a worker for duty at each of the three naval training stations at Norfolk, Virginia, Great Lakes, Illinois, and San Diego, California, and at the Marine Barracks, Parris Island, North Carolina, and the Marine Corps Base at San Diego, California. Psychiatric social workers have already been assigned to most of these stations.

Red Cross salaries for staff psychiatric social workers will range from $150 to $175 per month; for semi-executives, from $175 to $200; for executives, from $175 to $225. These salaries are based upon the experience of the worker and the responsibilities assigned to her. The salary for foreign assignments, irrespective of status or responsibility, is $225, plus $45 flat maintenance, transportation, and insurance. Inquiries as to qualification requirements may be addressed to Miss Eleanor C. Vincent, Assistant National Director, Military and Naval Warfare Service, American Red Cross, National Headquarters, Washington, D. C.

England Needs Psychiatrists

The heightened activity of the various mental-health services in England, which have been developed to war pitch, both in the military forces and in civilian agencies, is reflected, among other ways, in the drain on psychiatric personnel concerning which information has reached us lately from several sources. The Commonwealth Fund of New York, which supports child-guidance clinics in that country and has done much toward the recruiting and the training of English workers for that field, reports that "mental-health services for children have literally proved themselves under fire," and intimates that everything possible has been done to make the most of the limited personnel available.

Recently, Dr. Clarence M. Hincks, General Director of the Canadian National Committee for Mental Hygiene, spent several weeks in England, studying the mental-hygiene problems of evacuated children, with a view to instituting a recruiting and training program with the aid of psychiatric, educational, and social-work leaders experienced in work with children in the United States and Canada.

The acute need for psychiatrists in the armed forces and in civilian posts was again brought to our attention the other day in a communication from Dr. J. R. Rees, Director of the well-known Tavistock Clinic in London and now consulting psychiatrist to the army, appealing for such help as we can give. "We have just succeeded," writes Dr. Rees, "in getting a service of selection of personnel instituted and are busy with personality tests for selecting officers, and a dozen other projects." He reports that psychiatric work in the army has been divided into three aspects: (1) clinical psychiatry; (2) social psychiatry (dealing with questions of morale, crime, relationships with most of the other departments of the army, and so on); and (3) industrial psychiatry (dealing with selection problems and the handling of the misfits). He then says: "We are very near the end of our competent psychiatrists, or at least it is very hard to get more of them released from their civilian jobs, so that it looks as though for the future we shall have to use doctors who are not psychiatrists, but who have an interest in the second and third types of work, giving them as much training as possible under present conditions. Only last night I was discussing the question of whether it would be possible to get a group of psychiatrists over from the States to help us. It would be very good if we could do that."

"Shell Shock" Explained

The attitude of Americans at home will determine to a large extent how many American boys come back from World War II with the condition popularly known as "shell shock" in the last World War, according to Dr. Karl M. Bowman, professor of psychiatry and Director of the Langley Porter Clinic of the University of California Medical School. In an instructive interview recently reported by *Science Service,* in which he clarified some misunderstood aspects of the war-neurosis problem, Dr. Bowman explained that "shell shock" is not the result of any pounding the nervous system takes from the explosion of shells or the whine of bullets, but is caused by mental conflict within the soldier. He is torn between the instinct of self-preservation, and the accompanying urge to get away from danger, and the so-called "herd instinct," which is drilled into him by the army and which calls upon him to accept any danger necessary to his duties as a true soldier and a loyal citizen.

"Assuming that the instinct of self-preservation is extremely small and the herd instinct very large, there is comparatively little conflict," Dr. Bowman said. "The herd instinct triumphs and we have what is called repression of this other tendency." However, when morale is low, when unstable troops are used, or when shell

shock is glorified, the incidence of shell shock jumps. Shell shock, Dr. Bowman pointed out, is one of many solutions to the mental conflict of the soldier. Other solutions are the use of alcohol or drugs, being wounded, being taken prisoner, committing suicide, and malingering. Shell shock, however, may unconsciously be selected by the unstable soldier as the most desirable solution; it not only removes him from danger, but there is no stigma attached to it. Here is the nub of the problem involving factors of attitude and behavior on the part of the folks back home, as Dr. Bowman brings out.

"If war neurosis is accepted and glorified, as was done at times during the last war, the incidence will increase," Dr. Bowman said. "At one time the British Army gave wound stripes for shell shock, and it did not take them long to realize that that was a serious mistake. The frequency of the condition increased enormously. That is, the minute official approval was put on the development of a war neurosis, every possible incentive was given to a man to develop it. Therefore, if the public, also, glorifies so-called shell shock, that will increase its incidence.

"Now, all sickness is due to the fact that the organism is inadequate for dealing with its environment, and sickness is never a thing to be proud of. On the other hand, it is not something to blame the individual for, but all sickness is a confession of inadequacy, and the same is true with regard to the war neuroses. It is a confession that the individual's emotional system, and his nervous mechanism, is inadequate for dealing with the stress and strain to which he is subjected. He is not to be punished for this, but he is not to be praised for it. It is nothing to boast about. So it is important that both in the army and in our civilian groups we take this middle-ground attitude toward the war neuroses."

Dr. Bowman, who is one of the country's outstanding psychiatrists, served with the army in World War I and is now a reserve officer in the Navy Medical Corps.

State Society News

California

Mental-health issues in relation to the war effort receive major attention from the contributors to the first issue of *Beacon*, the new bulletin of the Mental Hygiene Society of Northern California, just published. The leading article, entitled *Children in War*, is a report by Dr. Joseph Solomon of a panel discussion, held under the auspices of the society on February 10, on the effects of war on children's behavior. This is followed by a discussion of Selective Service psychiatry, by Dr. Mervyn H. Hirschfeld; a report on the society's

growth and activities, by its president, Dr. Ernst Wolff; an article, by Miss Annie Clo Watson, on "Our Aliens," in which a plea is made for a rational approach to the problem of dealing with Axis nationals on the Pacific coast; and an editorial on the newly formed California Youth Correction Authority.

Discussing the society's war-work interests, Dr. Wolff writes: "A committee of psychiatrists, presided over by Dr. Jacob Kasanin, has prepared lectures on the mental-hygiene factors in civilian defense and disaster relief which the Red Cross plans to include in its volunteer training courses. We have discussed with the regional headquarters of the Office of Civilian Defense the development of a mental-hygiene program for this area. Under consideration is the preparation of a study course for use in civilian-defense classes in those communities where leadership is not available. We are drafting a series of radio broadcasts and hope to create a panel of consultants who will be available through correspondence to the rural areas."

The following officers were elected by the society at its meeting on February 10: President, Dr. Ernst Wolff, of San Francisco; 1st vice-president, Dr. Lois Meek Stolz, of Oakland; 2nd vice-president, Miss Barbara A. Mayer, of San Francisco; secretary, Miss Mary Rapp, of San Francisco; treasurer, Philip N. Lilienthal, Jr., of San Mateo; and members of the board of directors, Dr. Karl M. Bowman and Miss Marian Russell, of San Francisco.

Delaware

The Delaware Society for Mental Hygiene and the Delaware Red Cross have joined forces in the training of women volunteers as "convalescence counselors" for service in army and navy hospitals and clinics, veterans' hospitals, and Red Cross centers. Functioning as members of the Hospital and Recreation Corps of the American Red Cross (otherwise known as the Gray Ladies), convalescence counselors will work under the direction of competent medical staffs, organizing amusements, games, and entertainments, acting as hostesses when relatives of patients visit hospitals, and instructing patients in practical handicrafts under the supervision of professional occupational therapists.

The training program is premised on the assumption that a large percentage of the problems of convalescence are of a mental-hygiene nature and require the attention of workers trained in this field. The training course, which will be given under the direction of Mrs. G. Dudley Gray, Chairman of the Hospital and Recreation Corps of the Delaware Red Cross, and Colonel H. Edmund Bullis, Executive Director of the Delaware Society for Mental Hygiene, will require a

minimum of fifteen hours' attendance a week during a five-week period, followed by ten hours a week during a two-week internship in Delaware hospitals. In addition, fifteen hours of homework in connection with handicraft projects will be required, making a total training time of one hundred and ten hours.

Associate directors of the course will be Alfred Kamm, Managing Director of the Boys Club of Wilmington, and Miss Clarice Ferguson, Chief Occupational Therapist of the Delaware State Hospital. A special advisory committee under the chairmanship of Dr. M. A. Tarumianz, Superintendent of the Delaware State Hospital, will outline the program and assist in enlisting volunteer instructors for the course.

Illinois

A round table on "Mental Health Problems in War Time" was the high point of interest at the annual meeting of the Illinois Society for Mental Hygiene, held in Chicago on March 7. The meeting was designed for parents, teachers, social workers, and others who have to face the difficulties of those who look to them for guidance in problems of adjustment precipitated or aggravated by the war situation. The discussions began with a consideration of local problems, which were then related to problems of mental health and morale confronting the state and the nation. The December issue of the society's *Mental Health Bulletin* reprinted as its leading article a set of practical "Suggestions to O.C.D. Personnel for Talks on Morale," prepared by Dr. Jules H. Masserman, psychiatric adviser to the Civilian Defense Committee. They are offered to speakers on civilian morale who may be asked to talk to block captains, district supervisors, or other citizens participating in civilian-defense activities.

Maryland

The Mental Hygiene Society of Maryland has devoted a substantial share of its activities during 1941 to war work, especially in coöperation with Selective Service, according to the recent annual report of its executive secretary, Dr. Ralph P. Truitt. To the society's mental-hygiene clinic were referred for psychiatric examination in this period some 270 draft registrants, the Medical Advisory Board constituting the largest single source of cases referred among all of the clinic's new cases. Of this number a considerable percentage were rejected as unsuited for military service. "Each such rejection," says Dr. Truitt, "means the prevention of a potentially severe problem of maladjustment and, in many cases, breakdown under military training and service. Ultimately each case rejected may

represent a saving of thousands of dollars in compensation and in hospital care in the post-war period."

Michigan

The Michigan Society for Mental Hygiene reports the appointment of Dr. Frank F. Tallman, former clinical director of the Rockland State Hospital, Orangeburg, New York, as Director of Mental Hygiene of the Michigan State Hospital Commission, with headquarters at Lansing. Dr. Tallman will have charge of the organization, supervision, and coördination of the state child-guidance clinics; the establishment of a boarding-out and colony program; the coördination and expansion of hospital out-patient clinics, in collaboration with the state-hospital superintendents; and the development of an integrated state-wide educational and preventive mental-health program. The State Hospital Commission is a seven-member board charged with the responsibility of supervising and directing the state mental hospitals and of carrying out a program of prevention. Charles F. Wagg, executive secretary of the commission, carries out its functions with respect to the state hospitals. Dr. Tallman will direct its activities in the field of prevention.

Missouri

Mindful of the peculiar responsibilities of mental-hygiene organizations in meeting problems precipitated by the present emergency, the Missouri Association for Mental Hygiene has formed a special committee to study and deal with these problems in relation to the defense program in the state. The committee is headed by Dr. B. Landis Elliott, of Kansas City, and the membership is made up of psychiatrists from various parts of the state. A program is in process of development for activities aimed at the satisfactory adjustment of rejected draftees, of members of families whose homes have been disrupted by the draft and enlistments, of children and adults who have been crowded into new defense communities whose facilities have not yet been expanded to meet their needs, and so on. The group of psychiatrists engaged in this effort plan to work in close coöperation with the state Selective Service System and with other agencies concerned with mental-health defense problems.

New York

The New York City Committee on Mental Hygiene and the Mental Hygiene Section of the Welfare Council has offered its services to local representatives of the Office of Civilian Defense and other

authorities and agencies concerned with mental-health problems relating to the war, as a clearing house of information and for the coördination of plans for additional mental-hygiene services in the city. Resolutions to this effect were adopted at a meeting of the executive committee on January 14, and addressed to the Mayor; to the Chief of the Emergency Medical Service of New York City; to the Medical Officer of the Second Civilian Defense Region; to the Director of the Medical Division of Selective Service, New York City, the deputy chief inspector of the police department, and the Chairman of the Greater New York Civilian Defense Volunteer Office. At an open meeting of the Mental Hygiene Committee and Section, held on February 13, ways and means to implement the mental-health war program were discussed. Among the more immediate activities resulting from this move was the preparation of a guide for use in training air-raid wardens in certain aspects of "mental preparedness" necessary for the protection of civilians before and during air raids. Dr. George S. Goldman, of the Emergency Committee of Neuropsychiatric Societies, is the author of the guide, which will be widely distributed.

Oregon

"Mental Health and Morale" was the theme of a special course of lectures sponsored by the Oregon Mental Hygiene Society during the past few weeks for the benefit of its members and the general public. The following topics indicate the scope of the lectures, which were given by psychiatric and other leaders of the state: *Lessons in Mental Health Taken From the English War Experience; German Psychological Warfare; Selective Service Psychiatry, Its Implications for the Army and the Community; Our Emotional Reactions to the Emergency;* and *Mental Health in Total War.*

Texas

How to "take mental hygiene to the people" was impressively demonstrated in an educational project recently reported by the Lamar County Society for Mental Hygiene in Paris, Texas. Aided by the Hogg Foundation of the University of Texas, which furnished the speakers, the society joined with Paris Junior College in organizing a three-day mental-hygiene conference, which was held on November 3, 4, and 5, after a thorough preparatory canvass of the community. Eight outstanding speakers from various sections of the country were secured, representing the following fields: child guidance, elementary education, vocational guidance, sociology, religion, and rural community organization for mental hygiene. A

wide appeal was made to all the professions, to civic and club workers, and to the average layman, to interest them in the dissemination of mental-hygiene principles, and all newspapers in the area aided freely in publicizing the conference. Special meetings were organized for these various groups, community-center meetings were conducted throughout the county, and informal conferences with junior-college and high-school students in both large and small communities were held throughout each day. In addition, general evening sessions were held. Some 1,500 adults and 2,500 students took part in the various meetings. Some of the speakers made as many as three appearances at the day sessions and then appeared as main speakers at the evening sessions. Subsequently follow-up speakers were sent throughout the area to maintain and capitalize the interest in mental hygiene generated at the conference.

Protest Move to Drop Mental-Institution Statistics

Mental-health workers throughout the country are disturbed over the threat to discontinue certain functions of the Federal Census Bureau as they relate to the reporting and analysis of mental-hospital statistics. Under pressure for needed economies in non-defense expenditures, the Bureau of the Budget has struck out all appropriations for this important activity in the estimates submitted to Congress for the new fiscal year beginning July 1, 1942.

Enumerations of patients in mental institutions have been made by the Census Bureau for many years. The valuable data thus secured have provided, among other things, a basis for estimating the hospitalization needs of the mentally ill and defective, and have enabled state authorities to watch the trends in frequency of the various types of mental disorder and to undertake medical, legal, educational, and social measures for their treatment, control, and prevention. These data have also made possible much of the planning, study, and research that are fundamental and indispensable to activity and progress in the whole broad field of mental hygiene. Their elimination at this time would cause an irreparable break in mental-disease statistics and thus preclude their use in determining the effects of war conditions on the nation's mental health.

Equally important are the facts and figures relating to delinquency and crime, which have been made available each year through the collection of institution statistics by the Bureau of the Census. Appropriations for these two fields of activity, which for the last fiscal year amounted to fifty thousand dollars, have always been made jointly. Representations have been made to Congress in the hope that the threatened discontinuance of these annual enumerations, and

its disastrous results, may be averted, with a plea for curtailment, if necessary, rather than total elimination of the reporting of basic data so necessary to mental-health work, both during the emergency and after.

Financing America's War Effort

Responsive to a request from the Treasury Department, we are glad to bring to the attention of our readers the opportunity afforded to all of us, whatever our individual relations to the national war effort in terms of personal service, to sustain this effort toward a successful end by investing in it financially as well.

Mental hygiene, like every other American movement for individual and social betterment, has a vital stake in the outcome of the present conflict, in which the supreme issue is the survival of freedom and all that it implies for our way of life. The aims of this movement for the mental well-being of our people are inextricably bound up with the human and spiritual values inherent in our democratic civilization, drawing their strength from and contributing to the preservation of these values, and we cannot be concerned over the one without being concerned over the other.

It behooves each and every one of us, therefore, to put our shoulder to the wheel of production, and every other aspect of America's total effort toward victory, by helping our Government to the fullest extent of our resources to meet the costs of this effort by participation in its War Savings Program. Not only does the money invested in War Savings Bonds and Stamps buy tools of war. These dollars are substracted from consumer purchasing power, which helps to curb inflation, and for us as individuals, War Bonds represent savings which grow in value and build toward our own future security.

There are registered, interest-bearing bonds for all individuals and associations among the Series E, F, and G War Bonds offered by the Treasury Department. The smallest of the "People's Bonds" cost $18.75 and pays $25.00 at the end of ten years. The largest Defense Bond costs $10,000 and pays 2½ per cent interest throughout its 12-year maturity period. War Stamps cost from 10 cents to 5.00 and stamps build toward bonds.

The Lucius N. Littauer Fund for Psychiatric Research and Training Established at New York University

It is gratifying to report that original investigation into the nature and causes of mental and nervous disorders has received a further stimulus through the generosity of Lucius N. Littauer, of New York,

long a friend and benefactor of psychiatry and mental hygiene. His latest benefaction in this field provides for the setting up of a fund of approximately $250,000 at the College of Medicine of New York University for research in psychiatry, neurology, and related fields, "in order to increase and diffuse knowledge of the biological and other factors which influence thought and conduct, and thereby to prevent and correct abnormal human behavior through experimental and clinical approaches." Chancellor Harry Woodburn Chase, in announcing the gift, said that part of the income from the fund would be devoted to fellowships for graduate medical students "of superior ability," to be known as "Littauer Fellows," as an aid in the recruiting of physicians "especially devoted to the conservation and restoration of mental health." Mr. Littauer thus contributes at one and the same time to two vital aspects of an important medical and public-health problem for which financial help is greatly needed at this time, and we are encouraged to hope that his liberal philanthropies in this hitherto neglected field will be emulated by donors similarly attracted to the support of scientific investigation and training at other psychiatric centers of the country.

American Psychiatric Association to Meet in Boston May 18–22

Military psychiatry will be prominently featured at the Ninety-eighth Annual Meeting of the American Psychiatric Association, which will be held at the Hotel Statler, Boston, May 18–22, under the presidency of Dr. J. K. Hall. One section meeting will be devoted to "Morale and Military Psychiatry," at which papers will be presented on such topics as morale, the rôle of psychiatric social workers in Selective Service, a survey of the neuropsychiatric work at the Boston Induction Station, air-crew selection, social data in psychiatric casualties in the armed services, and postgraduate courses in military neuropsychiatry for civilian physicians. Another section will deal with various aspects of the psychiatric program of the United States Navy. In addition, there will be round tables on military psychiatry, on the application of psychoanalysis to the national emergency, on civilian mental health and morale, and on psychiatric nursing in the emergency.

Among the clinical, therapeutic, pathological, and other technical sessions will be a symposium on dementia praecox at which papers will be read by several of the investigators engaged in the Scottish Rite dementia-praecox research program, administered by The National Committee for Mental Hygiene. The National Committee is also planning to hold a conference of representatives of state mental-hygiene societies at the Boston meeting.

War themes will also be stressed at a meeting of the Association for the Advancement of Psychoanalysis to be held at the Copley-Plaza Hotel, in Boston, on May 19. The program of this group will include a panel discussion on "Human Destructiveness," and a session at which "Psychoanalysis, Religion, and the World Crisis" and other topics will be discussed.

Mental-Hygiene Meetings Scheduled for National Conference of Social Work in New Orleans

The National Committee for Mental Hygiene will be represented among the associated groups conducting programs at the annual spring meetings of the National Conference of Social Work, which will be held in New Orleans, Louisiana, May 10–16. On Thursday, May 14, at the St. Charles Hotel, the National Committee will sponsor a symposium on "The Use of Family Care as a Procedure for the Mentally Ill," and a session on "Ways of Using Health and Welfare Information in Protecting Health in Relation to Military Service." This will be followed by a discussion of "Problems of Organization of Child Guidance Clinics." There will also be a joint meeting of the American Foundation for the Blind and The National Committee for Mental Hygiene on the topic, "After Blindness—What?" A conference of representatives of state mental-hygiene societies will also be held in New Orleans during the conference week.

New Publications

The past twelve months have seen a rapid growth of contributions to the professional literature on the psychiatric and mental-health aspects of the war emergency, as the Weekly Index of the National Health Library has shown. Any one wishing to keep abreast in his reading in this field will do well to avail himself of the bibliographic service offered by this publication, which lists, in annotated form, current articles appearing in a wide range of professional and non-technical periodicals covering every department of public health, physical and mental. Subscriptions, $2.50 a year, National Health Library, 1790 Broadway, New York City.

Of a more popular character and of great practical value to the layman, are certain mental-hygiene publications now beginning to appear in response to well-defined needs and presaging an increasing flow of mental-health war literature. Among these we recommend *To Parents in Wartime*, a brochure prepared for the United States

Children's Bureau by a committee of specialists in child guidance, education, and mental health, in answer to questions parents are asking about their children's protection against the anxieties and tensions of wartime. Copies may be had from the Government Printing Office, Washington, D. C., at five cents a copy. Ask for Publication No. 282.

Along similar lines is *Children in Wartime,* a smaller pamphlet issued by the Child Study Association of America, 221 West 57th Street, New York City. Price, five cents; in quantities of 100, three cents per copy, plus postage.

Another useful contribution is the series of radio broadcasts published by The National Committee for Mental Hygiene of Canada in a pamphlet entitled *The Child in Wartime.* Order from the committee, 111 St. George Street, Toronto, Ontario. Price, ten cents per copy; five or more copies, eights cents each.

For the adult, is Dr. Abraham Myerson's instructive article *Morale —The Front Within,* in the special "Keep Fit" number (March, 1942) of the *Survey Graphic,* now available in reprint form from The National Committee for Mental Hygiene, 1790 Broadway, New York City; five cents per copy.

Several psychiatric writers as well as specialists in other fields contribute to the 1941 Yearbook of the National Probation Association just published under the title *Probation and Parole Progress.* Many phases of the correctional problem are dealt with in this volume of 470 pages, including adult probation and parole, juvenile courts and crime prevention, and crime treatment generally. The book is designed not only as a practical help to the correctional worker, but as a useful source of information for the student and the lay reader. It is available in cloth at $1.75, and in paper binding at $1.25. Order from the Association at 1790 Broadway, New York City.

Summer Course in Neurology of Speech and Reading to Be Given in Boston

The Massachusetts General Hospital announces a special course of instruction in the causes and treatment of language problems, to be given by Dr. Edwin M. Cole and associates at the hospital in Boston during the month of July. The course will consist of twenty morning lectures and clinic demonstrations by physicians and educators, and will cover problems in speech and reading as seen by teachers in their daily work at school and by doctors in their practice. For further particulars write to Miss Miriam Phelps, Language Clinic, Box 396, Massachusetts General Hospital, Boston, Massachusetts.

Psychiatrist Discusses War-Time Problems of Children on Radio

Children in Wartime is the theme of a new series of radio broadcasts being given by the United States Children's Bureau to help parents safeguard their children against the stresses and strains of the emergency. They present, in dramatized form, true-to-life family situations in which common and uncommon mental and emotional problems related to war conditions are analyzed and interpreted by Dr. George S. Stevenson, Medical Director of The National Committee for Mental Hygiene. Listeners are invited to send to the Children's Bureau actual problems they wish discussed on the program. The broadcasts are given weekly over the Blue Network of the National Broadcasting Company on Tuesday afternoons, from 12:00 to 12:15, Eastern War Time.

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